Care and Caring: The Affordable Care Act, Health Coverage and LGBT Tennesseans

TENNESSEE HEALTH CARE campaign

PFLAG NASHVILLE

Acknowledgments

Many thanks to the individuals and organizations acknowledged below, who have helped fund, plan, prepare, review, re-review and update this document over several months. Efforts to monitor how national and state policies impact LGBT health in Tennessee, and to improve those policies, will continue during this volatile, uncertain time for health policy and LGBT rights.

Sponsor

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Partner Organizations

PFLAG-Nashville: Kathy Halbrooks and Michael Reding, co-chairs
Tennessee Health Care Campaign (THCC): Walter Davis, executive director

Reviewers and Advisors

Clare Sullivan, MSN, MSPH, Meharry-Vanderbilt Community Engaged Research Core coordinator
Gilbert Gonzales, assistant professor of Health Policy, Vanderbilt University Medical Center
Lauren Beach, JD, PhD, co-founder of Bi Tennessee
Jesse Ehrenfeld, MD, director, VUMC LGBTI Health Program
Larry Frampton, public policy director, Nashville CARES
Chris Sanders, executive director, Tennessee Equality Project

Research Interns

Grecia Magdeleno
Jarrett Harper

Editors

Andrea Hultman and Ashley Hultman of The Polished Opal
Joe Lopez

Cover Photo

Walter Davis

Note: The views included in this report do not represent the official position of the organizations listed here.

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Executive Summary

Initially, this report began as an examination of how the Patient Protection and Affordable Care Act of 2010 (ACA) improved health care access and outcomes for the lesbian, gay, bisexual or transgender (LGBT)* community in Tennessee. While the report discusses potential impacts of federal health care policy on LGBT people in Tennessee, an additional objective emerged: to emphasize how essential preserving the health care protections and civil rights advances contained within the ACA is. These Tennesseans lack protection from discrimination, which occurs not only in health care provided to LGBT people but also extends to housing, employment and education, creating overlapping issues to access care.

Health care protections for LGBT people are crucial to combat LGBT-based health disparities created by adverse environments and health behaviors. For instance, discriminatory environments and public policies can lead to feelings of rejection, shame and low self-esteem among LGBT people, which contribute to poorer health and mental health status that we see in LGBT communities in Tennessee. This report provides baseline information for monitoring LGBT health disparities and barriers to care for LGBT Tennesseans.

The Health of LGBT Populations in Tennessee

Adults who self-identify as a member of the LGBT community when surveyed make up 2.8 percent of Tennessee's adult population, though the actual percentage may be higher. Gallup Daily Tracking data, analyzed by the Williams Institute at the University of California, suggest that 10 percent of LGBT adults in Tennessee are unemployed and 17 percent of LGBT adults in Tennessee are uninsured. Both rates are higher, compared with non-LGBT adults in Tennessee—7 percent and 14 percent, respectively.

While little data exists on the health status, health behaviors and access to care for LGBT Tennesseans specifically, nationwide research suggests that LGBT people exhibit worse health outcomes, compared with non-LGBT people. Compared with data regarding experiences of people of other sexual orientations, research reveals that bisexual people report more numerous health care access challenges and worse mental health and substance use outcomes.

Accessing affordable health care may also be an issue for transgender Tennesseans. Approximately one out of three transgender Tennesseans reported experiencing negative encounters with health care professionals: being refused treatment, suffering verbal or physical harassment or having to inform providers about transgender-related health needs that clinicians should already be aware of and prepared to treat.

At the beginning of the project in the summer of 2016, a brief survey was conducted by Tennessee Health Care Campaign and PFLAG-Nashville to assess whether Tennesseans who identify as LGBT experienced or feared discrimination in accessing health care coverage and treatment. The results from the survey, whose sample was small and not selected at random, aligned with those of nationwide studies of randomized samples of LGBT Americans. The survey indicated that one in five LGBT persons, 20 percent, reported being denied services and one in three, 34 percent, felt discriminated against by a health care provider because of their gender identity, gender expression or sexual orientation.

* ***Note:*** This report uses the acronym *LGBT* to describe the broader LGBT population, and this umbrella term is inclusive of other sexual and gender minorities, including queer, two-spirit, intersex, asexual, gender nonconforming and gender nonbinary populations.

Changes the ACA Made to Insurance Coverage and to LGBT Patient Rights

The ACA made changes in health insurance coverage that impact the health care of LGBT persons, not only for those purchasing individual policies on the ACA marketplace but also for LGBT people who are insured through their employers. These new consumer protections included …

- defining essential and preventive health benefits (EHBs);
- prohibiting exclusions for pre-existing conditions;
- limiting medical underwriting, a practice where insurers charged ill policyholders more than healthier enrollees for services;
- prohibiting lifetime limits (insurers often limited how much they would pay out for medical services; once this limit was met, the company would not pay any more for services or benefits for the duration of the enrollee's or dependent's life);
- establishing of out-of-pocket maximums (OOPMs), upper limits on how much consumers would be responsible for paying medical providers for services, a protection that prevents insurance companies from shifting medical costs to consumers than paying out benefits at exorbitant rates;
- promoting parity of mental health care coverage;
- and prohibiting forms of sex and gender discrimination.

Most notably, Section 1557 of the ACA prohibits discrimination based on sex, defined to include gender identity and sex stereotypes, in addition to prohibiting discrimination based on race, color, national origin, age, disability and limited English proficiency. The section also requires health programs receiving federal funding, health insurance marketplaces and health plans offered in those marketplaces to provide transgender individuals equal access to publicly funded programs, including health care facilities, without discrimination.

Section 1557 has resulted in all Tennessee marketplace carriers in 2017 offering gender reassignment surgery and ongoing maintenance hormone treatments, as long as health criteria developed by the World Professional Association for Transgender Health (WPATH) are met. However, questions persist about whether these ACA protections will remain in full effect, and enforcement of Section 1557 is now in jeopardy.

Impact of 2017 ACA Marketplace Plans on LGBT Health in Tennessee

The transparency of the ACA marketplace exchange (Healthcare.gov) allows consumers to compare the details of coverage and cost among different plans offered based on county of residence. As part of this project, THCC and PFLAG-Nashville compared plans on Healthcare.gov across the eight geographic divisions, called rating areas and determined by the Tennessee Department of Commerce and Insurance, that insurers use to establish prices.

This comparison shed light on how differences in the costs of care and competition among insurers can impact prices for consumers, highlighting the complicated choices individuals must weigh to select a marketplace plan. These choices involve whether to select plans with higher premiums versus higher deductibles and cost-sharing arrangements. Considering cost-sharing arrangements includes weighing copayments versus coinsurance amounts. Examples show how differences in the pricing of medications and the structuring of provider networks, via rating areas, impact the cost and comprehensiveness of care. This dynamic can inform weighing any private insurance options or selecting among plans offered by employers.

A key factor for LGBT Tennesseans is whether health care providers understand their particular health needs. Significantly, none of the insurers on the marketplace has a system in place for verifying whether a provider received training in LGBT health or is welcoming of LGBT persons in their practice. Finding in-network specialists also becomes more challenging at distances further away from the large metropolitan regions: people residing in rural and suburban areas face more obstacles to access care.

Other provisions of the ACA impact the health of LGBT persons. The state legislature rejected the expansion of Medicaid—known as TennCare in Tennessee—in 2015, which prevented federal funds from extending health care coverage to additional uninsured Tennesseans with incomes below 138 percent of the Federal Poverty Level (FPL). In Tennessee, many LGBT individuals fall within this income range, including those working in the arts, entertainment and food service industries, along with students and young adults lacking financial support from families due to conflicts created by family members' prejudices about their sexual orientation or gender identity.

The intent for this report was to identify how the ACA improves access to care for LGBT Tennesseans and where barriers still remain. THCC and PFLAG-Nashville are committed to working with LGBT and health organizations across Tennessee to identify solutions to barriers preventing health equity for the LGBT community. Those solutions may consist of promoting education about LGBT health issues, advocating for inclusive legislation instead of exclusive or working with health professionals to establish more welcoming, supportive environments within clinical and other health care settings.

Introduction: Purpose of the LGBT Health Care and Caring Project

The original purpose of this report was to examine how the Patient Protection and Affordable Care Act of 2010—known as "Obamacare" or the Affordable Care Act (ACA)—has improved health care access and outcomes for the LGBT community. An additional objective became apparent as the project evolved from the time the Tennessee Health Care Campaign (THCC) and PFLAG-Nashville began this work in the summer of 2016: emphasizing how vital it is to all Tennesseans to preserve the health care and civil rights advances included in the ACA.

Why Is LGBT Health and LGBT Policy Important?

People who are lesbian, gay, bisexual or transgender (LGBT) won major legal victories in the past decade. LGBT people gained the opportunity to serve openly in the armed forces; in every state, to marry the person they love; to have the federal government recognize those marriages; and to have their health disparities targeted for elimination in national health policy.[1] Partly in response to recent legal and policy changes, more LGBT people have "come out" and affirmed their personal identities publicly. These changes may have contributed to lessened stigma. However, data points to the continued existence of stigma and recent efforts to curtail rights and protections of LGBT people may increase it. In 2016, approximately 10 million, or 4.1 percent, adults in the United States identified as LGBT, which was up from 8.3 million, 3.5 percent, in 2012.[2]

However, recent policy debates have focused on restricting the rights, privileges, and protections for LGBT people at national and state levels. For example, the First Amendment Defense Act (FADA)—which was introduced in the last session of Congress but died in committee at the end of 2016—would prevent the federal government from taking legal action against a person who believes that (1) marriage is or should be recognized as the union of one man and one woman or (2) sexual relations are properly reserved to such a marriage.[3] The bill's sponsor, Congressman Paul Labrador, said he would re-introduce FADA in the 115th session of Congress, which began in 2017, but the legislation has not been reintroduced in the current Congressional session. State-level versions of FADA could potentially emerge around the country in 2017.

Other proposed legislation in Congress would allow states to consider amending the U.S. Constitution to define marriage between one man and one woman, which threatens marriage equality for LGBT people nationwide.[4] While this most recent bill died in committee at the close of the last Congressional session, and because bills can often be introduced in multiple Congressional sessions, it is highly likely the bill's sponsor will reintroduce the legislation in the current Congressional session, which ends on December 31, 2018.

While this report discusses potential impacts of federal health care policy on LGBT health, it is equally important to acknowledge that LGBT people in many states, including Tennessee, lack protections from discrimination in health care, housing, employment or education. Only 21 states—mostly in the Northeast, upper Midwest or Western region of the country—protect LGBT people from employment discrimination.[5] Several of the same states prohibit LGBT-based discrimination in housing, education and public accommodations.

1. Institute of Medicine, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*, (Washington, DC: The National Academies Press, 2011).
2. Gary J. Gates, "In US, More Adults Identifying as LGBT," Gallup, published 2017, accessed 22 January, 2017: *http://www.gallup.com/poll/201731/lgbt-identification-rises.aspx*.
3. First Amendment Defense Act, H.R. 2802, 114th Cong. 2015.
4. Marriage Protection Amendment, H.J. Res. 32, 114th Cong. 2016.
5. Human Rights Campaign, 2016 State Equality Index, Washington, DC: Human Rights Campaign, 2016. *http://www.hrc.org/campaigns/state-equality-index*

Current state policy debates in the Tennessee General Assembly have targeted LGBT people. For example, the Natural Marriage Defense Act—state Senate Bill (SB) 752 and its equivalent, state House Bill (HB) 892—would require the state government to define and defend the definition of natural marriage as only between one man and one woman, regardless what other courts decide. A so-called "bathroom bill," SB771/HB888, would require transgender students to use the bathroom based on their sex assigned at birth and not by their gender identity. Another proposal, SB127/HB54, would prohibit state and local governments from taking action against a business based on a business' internal policies, which opens the door to economic and employment-based discrimination against LGBT people. While these other state-level legislative proposals did not pass in 2017, Governor Bill Haslam has signed the "LGBT erasure bill," referred to as the "natural meaning bill," SB1085/HB1111. This law requires "undefined words be given their natural and ordinary meaning" in Tennessee, which suggests that legislation and litigation may be open to interpretation that fails to recognize LGBT families.

Many public health studies have demonstrated that living in a state without LGBT protections is harmful to LGBT health.[6] Discriminatory environments and public policies can increase stigma; promote discrimination; and provoke feelings of rejection, shame and low self-esteem among LGBT people—contributing to poorer health and mental health statuses among LGBT communities in Tennessee and in other communities where discrimination is experienced intensely. This report provides baseline information for monitoring LGBT health disparities and barriers to care for LGBT Tennesseans, a foundation for policymakers, advocates, patients and their allies to take action and address LGBT health disparities through inclusive and equitable policy and access to care.

6. Mark L. Hatzenbueler, Katherine M. Keyes, Deborah S. Hasin, "State-Level Policies and Psychiatric Morbidity in Lesbian, Gay, and Bisexual Populations." *American Journal of Public Health* 99, no. 12 (December 1, 2009): 2275–2281. doi: *10.2105/AJPH.2008.153510*.

Mark L. Hatzenbueler, Katie A. McLaughlin, Katherine M. Keyes, Deborah S. Hasin, "The Impact of Institutional Discrimination on Psychiatric Disorders in Lesbian, Gay, and Bisexual Populations: A Prospective Study," *American Journal of Public Health* 100, no. 3 (March 1, 2010): 452–459. doi: *10.2105/AJPH.2009.168815*.

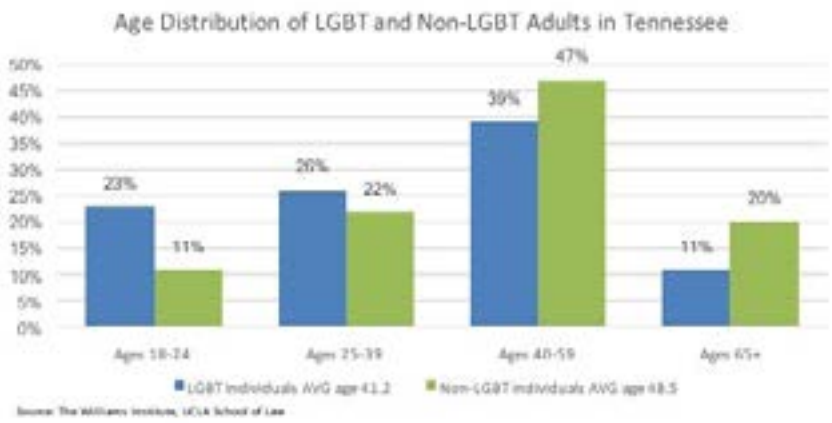
Mark L. Hatzenbueler, "How Does Sexual Minority Stigma 'Get Under the Skin'? A Psychological Mediation Framework" *Psychological Bulletin* 135, no. 5 (September 2009): 707–730. doi: *10.1037/a0016441.How*.

Section 1

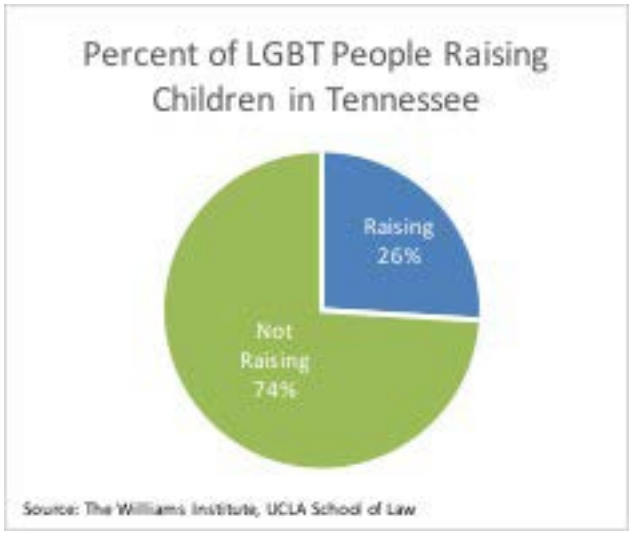
The Health of LGBT Populations in Tennessee

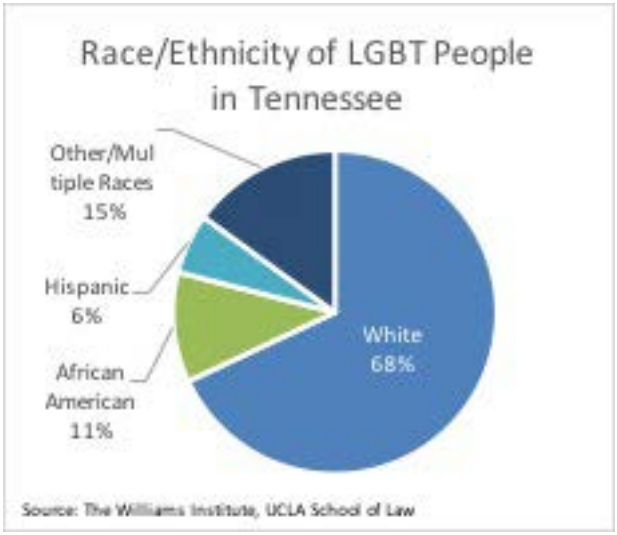
Photo Credit: Walter Davis, 2016

Section 1: The Health of LGBT Populations in Tennessee



According to the Daily Tracking data of Gallup, a nationally recognized research and polling firm, analyzed by the Williams Institute at the University of California, LGBT adults make up 2.8 percent of Tennessee's adult population.[1] The actual percentage may be higher because this estimate does not include people who choose not to disclose their sexual orientations to a survey interviewer. The average age of an LGBT adult in Tennessee is 41.2 years, which is lower than the average age of a non-LGBT adults in Tennessee (48.5 years). Distribution of "out" LGBT Tennesseans tends to be concentrated in younger age groups. Approximately 23 percent of LGBT Tennesseans are 18 to 24 years of age, while only 11 percent of non-LGBT Tennesseans are 18 to 24 years of age. Approximately 11 percent of LGBT Tennesseans are 65 years of age or older, while more than 50 percent are 39 years of age or younger. Interestingly, about one out of four LGBT Tennesseans (26 percent) are raising a child in the household.



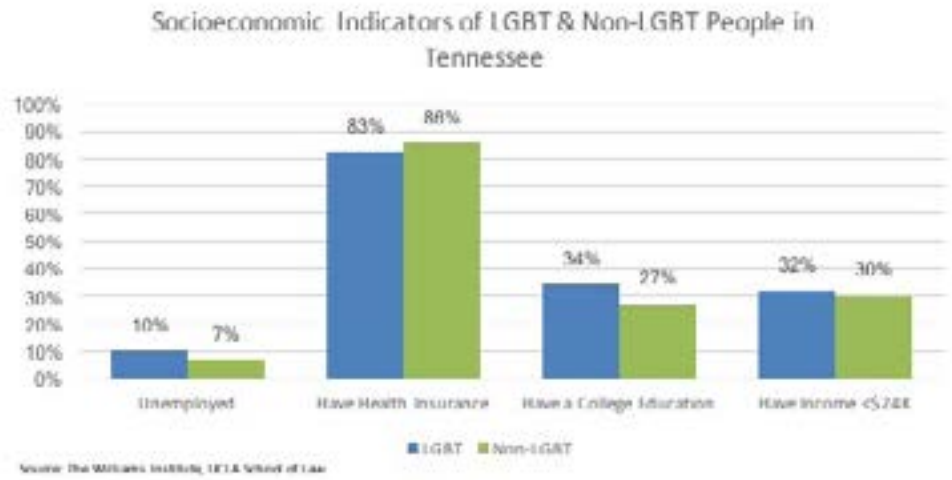


Sixty-eight percent of LGBT Tennesseans are white; 11 percent are African American; 6 percent are Hispanic; and 15 percent identify as another racial group: Asian, American Indian, multiethnic, etc.

LGBT Tennesseans share several socioeconomic characteristics with their non-LGBT peers and, in some cases, report worse socioeconomic statuses. According to Gallup Daily Tracking data analyzed by the Williams Institute, 10 percent of LGBT adults in Tennessee are unemployed, higher than the 7-percent unemployment rate for non-LGBT adults in Tennessee. Seventeen percent of LGBT adults in Tennessee are uninsured, higher than the 14-percent uninsured rate for non-LGBT adults in Tennessee. Finally, 32 percent of LGBT adults in Tennessee are living on annual incomes less than $24,000, slightly more than 30 percent of non-LGBT adults in Tennessee. These differences are surprising, given that more LGBT adults in Tennessee have a college degree, 34 percent, than do non-LGBT adults in Tennessee, 27 percent. These percentages may indicate higher rates of employment discrimination.

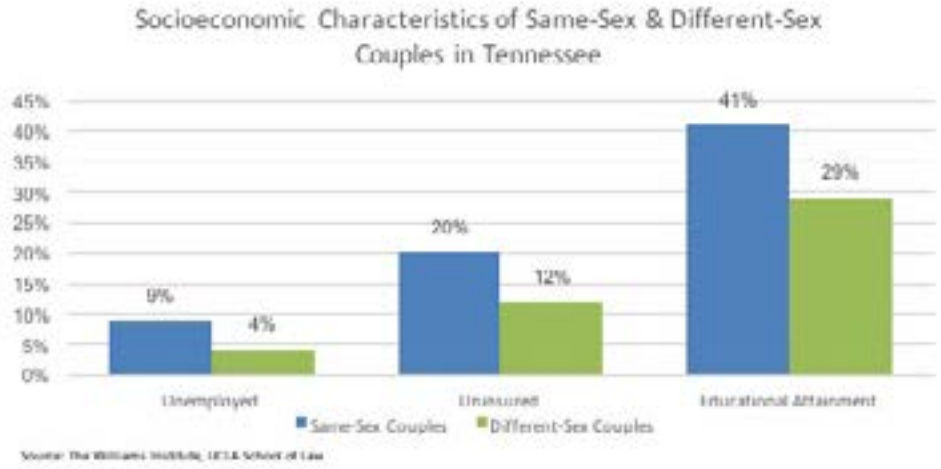
1. The Williams Institute, "Population Density of Same-Sex Couples," *Same-Sex Couple Data and Demographics*, Los Angeles: UCLA School of Law, 2016, accessed March 27, 2017, *https://williamsinstitute.law.ucla.edu/visualization/lgbt-stats/#density.*

Data from the American Community Survey conducted by the U.S. Census Bureau, also analyzed by the Williams Institute at UCLA Law, provides another portrait of same-sex couples in Tennessee. Approximately 10,900 same-sex couples reside in Tennessee, or 4.38 same-sex couples exist for every 1,000 households.



Most same-sex couples in the state, 57 percent, are female same-sex couples; 43 percent are male same-sex couples. Approximately 18 percent of same-sex couples—nearly one in five—are raising children. Approximately 81 percent of same-sex couples are headed by people who are white; 12 percent, by persons who are African American; 4 percent, by people who are Hispanic; and 3 percent, by persons who identify as part of another racial group.*

* ***Note:*** Due to the limits of the U.S. census's data, analysis about the percent of interracial LGBT couples was not available.



LGBT Health

Little data is available on the health status, health behaviors or access to care for LGBT Tennesseans, but research conducted in the United States suggests that LGBT people exhibit worse health outcomes compared with those of non-LGBT people. According to the Centers for Disease Control and Prevention (CDC)'s National Health Interview Survey, lesbian, gay and bisexual adults are more likely to report cigarette smoking, heavy drinking and exhibiting psychological distress, compared with their straight counterparts.[2] These differences in behavioral health are partly due to "minority stress": the stress associated with being a member of a marginalized and stigmatized minority group. Other research suggests that sexual minorities may be at greater risk of chronic health conditions, including certain types of cancer, HIV/AIDS and diabetes.[3]

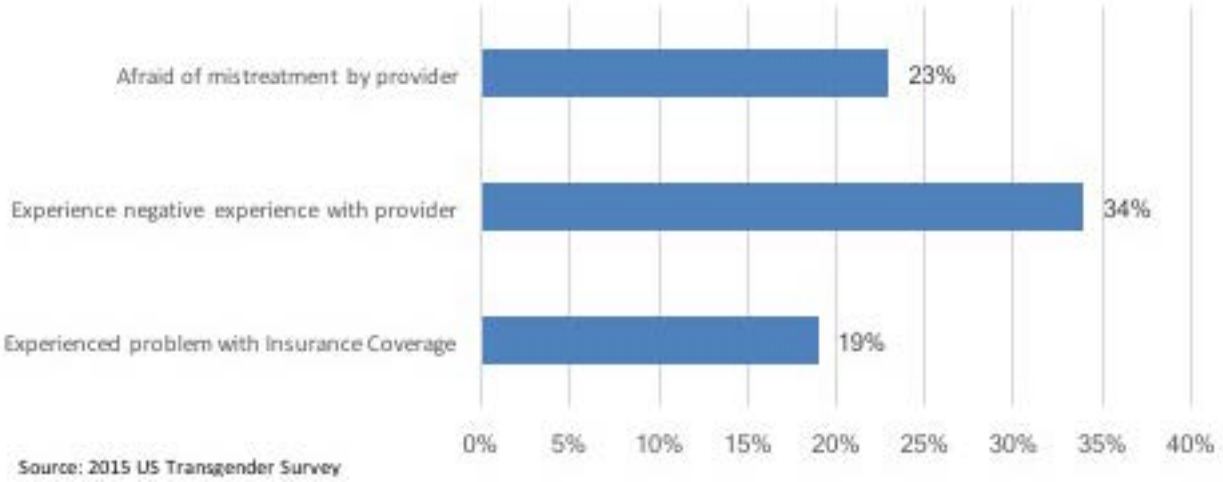
2. B. W. Ward, J. M. Dahlhamer, A. M. Galinsky, S. S. Joestl, "Sexual Orientation and Health Among U.S. Adults: National Health Interview Survey, 2013." *National Health Statistics Reports* 2, no. 77 (July 15, 2014): 1–12. *http://www.ncbi.nlm.nih.gov/pubmed/25025690*.
3. John R. Blosnich, G. W. Farmer, J. G. L. Lee, V. M. B. Silenzio, D. J. Bowen, "Health Inequalities Among Sexual Minority Adults," *American Journal of Preventive Medicine* 46, no. 4 (April 2014): 337–349. doi: *10.1016/j.amepre.2013.11.010*.

Chandra L. Jackson, Madina Agénor, Dayna A. Johnson, S. Bryn Austin, Ichiro Kawachi, "Sexual Orientation Identity Disparities in Health Behaviors, Outcomes, and Services Use Among Men and Women in the United States: A Cross-Sectional Study," *BMC Public Health* 16, no. 807 (August 2016): 1–11. doi: *10.1186/s12889-016-3467-1*.

Institute of Medicine, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* (Washington, DC: The National Academies Press, 2011).

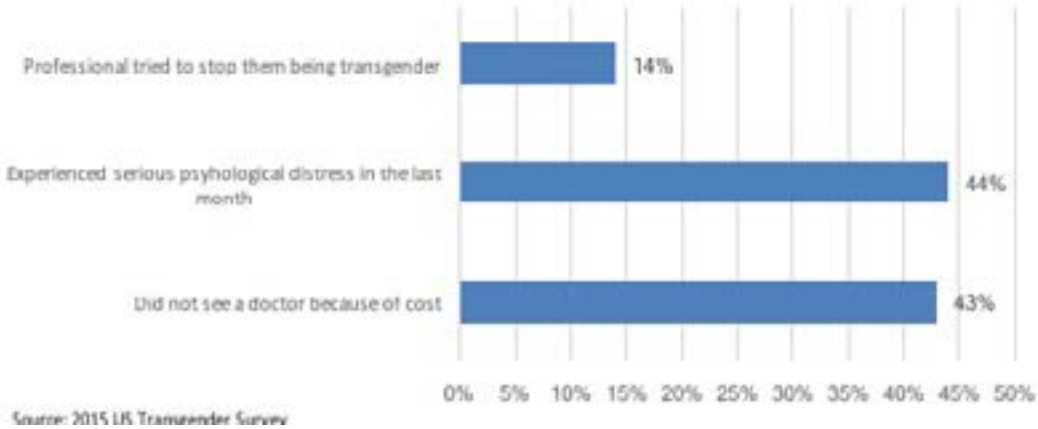
Recent research from the *2015 U.S. Transgender Survey* provides a snapshot, post ACA implementation, of the socioeconomic status and health of transgender Tennesseans.[4] Based on responses from 416 transgender residents, approximately 20 percent reported unemployment, and 34 percent reported living in poverty. Nearly half, 43 percent, of the transgender respondents in Tennessee with jobs reported previously being fired, being denied a promotion or having experienced mistreatment or harassment because of their gender identity or gender expression.

Percent of Individuals Reporting Health Access Problems Because of Transgender Status in Tennessee



Accessing affordable health care can present further challenges for transgender Tennesseans. According to the *2015 U.S. Transgender Survey*,[5] nearly one in five transgender Tennesseans reported problems with health insurance, including being denied health services related to gender transitions or being denied routine health care because of their gender identity or gender expression. Approximately one out of three transgender Tennesseans reported experiencing negative encounters with health care professionals, such as being refused treatment, suffering verbal or physical harassment or having to educate providers about transgender-related health services that clinicians should already be aware of.

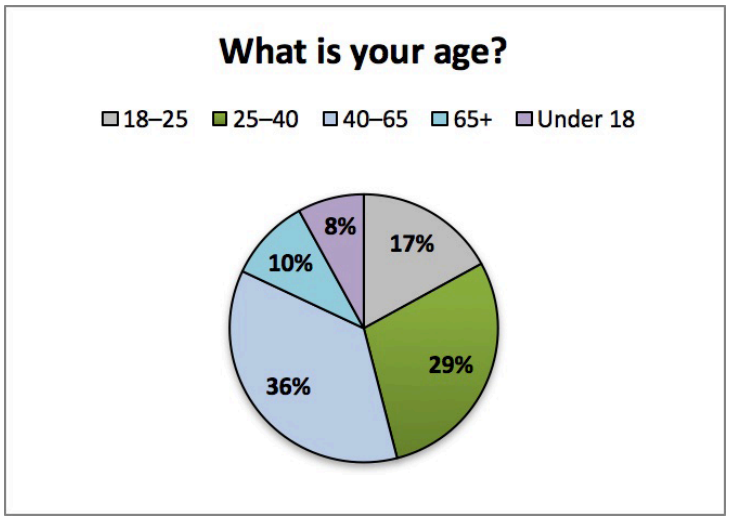
Health Disparities Among Transgender Individuals in Tennessee



4. S. E. James, J. L. Herman, S. Rankin, M. Keisling, L. Mottet, M. Anafi, *The Report of the 2015 U.S. Transgender Survey*, (Washington, DC: National Center for Transgender Equality, 2016), accessed 8 June 2017, *http://www.ustranssurvey.org/report.*
5. Ibid.

A recent study on the Invisible Majority: The Disparities Facing Bisexual People and How to Remedy Them by the Movement Advancement Project released in 2016, indicates that bisexual people, who comprise about half (52%) of LGBT people in the United States also face higher rates of bullying, domestic violence, workplace discrimination that results in lower incomes, and mental health disparities, including higher rates of depression, suicidal behavior, and substance abuse[6]. Data specific to bisexual populations in Tennessee was not available. Among sexual minorities, bisexuals are more likely to be living in poverty compared to people of other sexual orientations. A report by the Pew Research Center found that nationwide, 48% of bisexuals compared to 28% of all American adults, 39% of lesbians and 30% of gay men, were living on less than $30,000 per year[7].

Given the patterns of discrimination and disparity described here, it may not be surprising then that non-disclosure of sexual orientation to health providers can be a barrier to care. Although as yet no studies have been published on non-disclosure rates in Tennessee, other studies have indicated that rates of non-disclosure in more LGBT-welcoming communities such as New York City, are as high as 10% of gay men, 12.9% of lesbians, 32.6% of bisexual women, and 39.3% of bisexual men[8]. The U.S. Transgender Survey reports that only 28% of trans people are "out" to all their medical providers[4].



To assess whether Tennesseans who identify as lesbian, gay, bisexual or transgender (LGBT) experienced or feared experiencing discrimination in their health care, at the beginning of this project in the summer of 2016, a brief survey was conducted. Individuals were asked to share their age, sexual orientation, gender expression, current health care coverage, general health status and whether they felt they had been discriminated against by a health care provider or health care insurer because of their sexual orientation or gender identity. Online survey outreach consisted of notices in *Out & About Nashville*[9] and other LGBT-focused publications and distribution of a paper version of the survey at 2016 Pride events across Tennessee. The sample was small—only 100 people—but the results aligned with the concerns that LGBT individuals had expressed across the nation.

Survey respondents were asked about their age and how they identified within the LGBT community. Over half of the Tennessee survey respondent sample, 54 percent, was under 40. Approximately one third of the sample, 31 percent, self-identified as transgender, significantly higher than the percentage of the LGBT community that identifies as transgender nationally. Fourteen percent of the sample self-identified another descriptor, such as *queer, questioning, gender nonconforming, nonbinary* or other terms more common among younger members of the broader LGBT community.

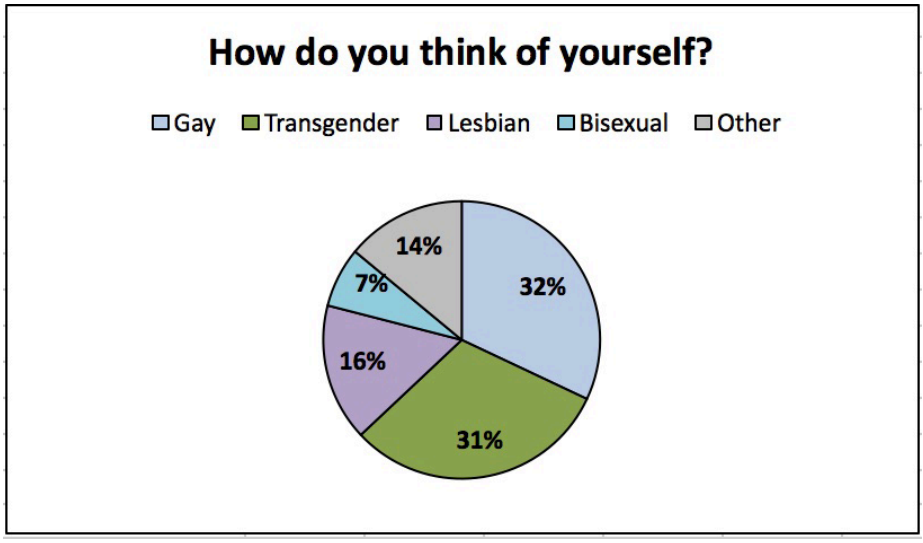
6. Movement Advancement Project, *Invisible Majority: The Disparities Facing Bisexual People and How to Remedy Them* (Boulder: Movement Advancement Project, 2016), accessed 8 June 2017, *http://www.lgbtmap.org/policy-and-issue-analysis/invisible-majority.*

7. Pew Research Center, *A Survey of LGBT Americans. (Washington DC,* June 2013). *http://www.pewsocialtrends.org/2013/06/13/a-survey-of-lgbt-americans/*

8. LE Durso and IH Meyer. "Patterns and predictors of disclosure of sexual oreintation to healthcare providers among lesbians, gay men, and bisexuals". *Sex Res Social Policy.* 10(1). (2013) 35-42. . doi: *10.1007/s13178-012-0105-1.*

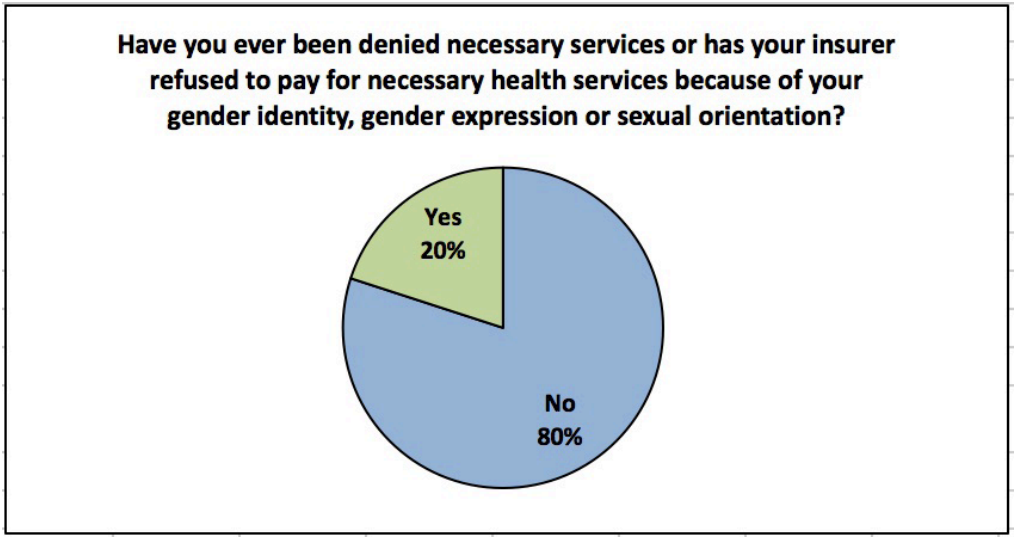
9. "TN Health Care Campaign Collaborates with PFLAG-Nashville," *Out & About Nashville*, published 2016, accessed 5 May 2017. *https://www. outandaboutnashville.com/story/tn-health-care-campaign-collaborates-pflag#.WQ1HYYjyuUk.*

The health insurance profile of the sample was similar to that for all adult Tennesseans. Excluding those on Medicare—because adults age 65 and over are universally covered—the coverage rates in our sample compared with coverage rates for other nonelderly adults in Tennessee are shown below.

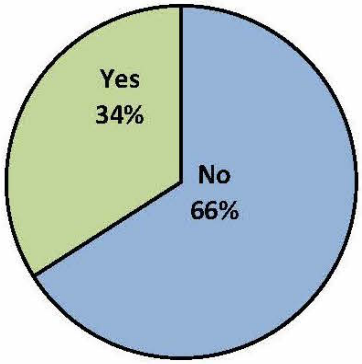


Type of Coverage	Tennessee Adults Ages 19 to 64 in 2016 [1.10]	PFLAG-Nashville–THCC Survey 2016
Employer-based plans	55%	55%
ACA marketplace plans	5.60%	6%
TennCare	13%	6%
None	16%	9%
Other	10.40%	14%

According to the respondents in our survey, one in five persons, 20 percent, reported being denied services, and one in three, 34 percent, felt discriminated against by a health care provider because of their gender identity, gender expression or sexual orientation. These findings are sobering, but they align with reports from national surveys described above. While the results are consistent with nationwide data trends, they do reinforce that changing Tennessee's health care system to be more caring and less discriminatory towards LGBT communities will require further education and advocacy on health care issues which affect LGBT communities at greater rates than the general population.

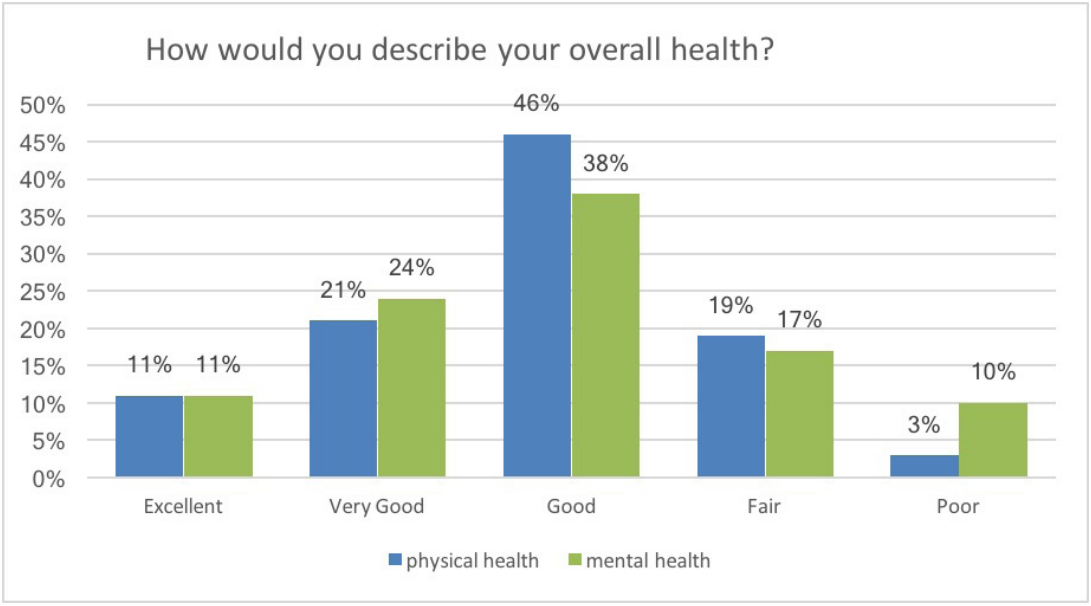


Have you ever felt discriminated against in receiving health care because of your gender identity, gender expression or sexual orientation?



Most respondents described their physical health as good, but one in five, 22 percent, reported only fair or poor physical health. These rates are comparable with data collected by the Centers for Disease Control and Prevention (CDC), which relayed that 21 percent of adult Tennesseans indicate poor or fair health.[10]

However, in this sample, more than one in four, 27 percent, described their mental health as only fair or poor. This statistic may result from minority stress, environmental and other factors, which warrant further research.



Conclusion

LGBT Tennesseans experience more barriers to care and worse health and socioeconomic outcomes, compared with their heterosexual and nontransgender peers. LGBT Tennesseans are more likely to be uninsured and unemployed and to have lower household incomes, compared with non-LGBT Tennesseans. The problems place LGBT people and their families at risk of widening health disparities, which contribute to adverse health outcomes of LGBT populations. Furthermore, transgender Tennesseans are especially vulnerable, as they are more likely to report negative experiences with health care providers and health insurance companies.

10. *BRFSS™ Prevalence and Trends Data*, Centers for Disease Control and Prevention, last updated 3 January 2017, accessed 5 May 2017, *https://www.cdc.gov/brfss/brfssprevalence/*.

Section 2

Changes the ACA Made to Insurance Coverage and to LGBT Rights

Photo Credit: THCC, 2016.

Section 2: Changes the Patient Protection and Affordable Care Act Made to Insurance Coverage and to LGBT Patient Rights

The Affordable Care Act (ACA) made sweeping changes to the way health insurance and health care are delivered in our country. The changes affected not only those buying plans on the ACA marketplace but also Americans who receive access to their care through employers benefits, Medicaid and even Medicare. With the ACA at risk of repeal and replacement, more Americans are realizing how important and broad the changes the ACA brought to health insurance and health care have been.

Six major changes the ACA made in health insurance coverage are covered here. They impact LGBT health care, not only for individuals purchasing policies on the ACA marketplace but also for LGBT people insured through employer-based plans.

Definition of Essential and Preventive Health Benefits

Before the ACA was signed into law in 2010, insurers could deny coverage and types of care to acutely or chronically ill patients. The ACA requires coverage of the following 10 *essential health benefits* (EHBs),[1] which the law defined as …

- outpatient care: doctor visits and care received through a medical center, without being admitted to a hospital;
- trips to the emergency room;
- inpatient care: health care received while admitted to a medical center/hospital;
- pre- and postnatal care: health care received before and after a baby is born;
- mental health and substance use services: behavioral health treatment, counseling and psychotherapy;
- prescription drug coverage;
- rehabilitative and habilitative services: services and devices to help patients recover or manage symptoms if one is injured or has or develops a disability or chronic condition(s); physical and occupational therapy, speech-language pathology, psychiatric rehabilitation, and more services fall within this category of care;
- lab tests and outpatient diagnostic imaging;
- preventive services: counseling, screenings and vaccines to keep patients healthy and care for managing chronic diseases;
- pediatric services: dental care and vision care for children and teens.

In addition, the ACA required preventive health services to be covered, with no copayment or coinsurance. *Copayments,* or *copays,* are fixed dollar amounts—for example, $15—a person pays for covered health care, usually when the patient receives the service. *Coinsurance* is the consumer's share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is $1,000, the coinsurance payment of 20 percent would be $200. This charge may change if the patient has not met the deductible, the amount paid out of pocket for care in full—100 percent of a charge—before the insurance plan starts to pay anything.

Preventive health services for all adults include[2] …

- abdominal aortic aneurysm one-time screening for men between ages 65 and 75 who have ever smoked;
- alcohol misuse screening and counseling;
- aspirin use to prevent cardiovascular disease for men and women of certain ages,

1. Center for Consumer Information and Insurance Oversight, *Essential Health Benefits Bulletin,* published December 2011, accessed 8 June 2017, *https://www.cms.gov/CCIIO/Resources/Files/Downloads/essential_health_benefits_bulletin.pdf.*
2. "Preventive Health Care Benefits for Adults," Healthcare.gov, accessed 8 June 2017, *https://www.healthcare.gov/preventive-care-adults/*

- blood pressure screening;
- cholesterol screening for adults between 40 and 75 or who have a family history of high cholesterol;
- colorectal cancer screening for adults over 50;
- depression screening;
- diabetes (type 2) screening for adults with high blood pressure;
- diet counseling for adults at higher risk for chronic disease;
- hepatitis B screening for people at high risk, including people from countries with 2 percent or more hepatitis B prevalence, and those born in the United States but who were not vaccinated as infants and have at least one parent born in a region with 8 percent or more hepatitis B prevalence.
- hepatitis C screening for adults at increased risk, as well as a one-time screening for those born between 1945 and 1965;
- HIV screening for those between the ages of 15 to 65, as well as screening for those under the age of 15 and over 54 who are at an increased risk for contracting HIV;
- immunization vaccines for adults, including hepatitis A and B, HPV, varicella and herpes zoster;
- lung cancer screening for adults 55 to 80 at high risk of lung cancer due to smoking history
- obesity screening and counseling
- sexually transmitted infection (STI) prevention counseling;
- syphilis screening;
- and tobacco use screening.

In addition, women are eligible also for breast cancer genetic counseling, mammography screenings, cervical cancer screening, osteoporosis screening and screening and care related to pregnancy.[3]

Prohibitions of Exclusions for Pre-Existing Conditions

The ACA prohibits health insurers from denying coverage or charging more to people with pre-existing health conditions. Prior to the passage of the Affordable Care Act and its being signed into law, people commented that being a woman was considered "a pre-existing condition." In fact, they were often charged more than men for similar health policies solely due to the possibility they might become pregnant. Before the ACA, persons with an HIV infection could also be excluded from coverage for any treatment related to HIV, almost ensuring their infection would lead to AIDS. Under the ACA, now any person living with a health condition such as HIV/AIDS, cancer, depression or a substance use disorder—health issues disproportionately affecting the LGBT population—cannot be denied coverage or charged higher premiums, compared with the premiums charged to people without pre-existing conditions.

Limits on Underwriting

Before the ACA, health care for chronic illnesses like diabetes or heart disease might be included in a policy, but insurance companies could charge much higher premium rates for persons with those illnesses. The practice of varying the cost of a policy with the health of the consumer is called medical underwriting. The only underwriting allowed by the ACA is for smoking status—smokers can be charged up to 150 percent of the premium for nonsmokers—and, to a limited extent, age. A person aged 63 can now be charged only up to 300 percent the premium for a person in their early 20s. With these two exceptions—age and smoking status—under the ACA, all Americans seeking coverage on the individual marketplace are considered part of the same "community" or risk pool.

Insurance companies offering plans on the marketplace, like insurers for large groups of employees or for Medicaid or Medicare populations, need to set their premium rates and design their copayments to be able to cover the costs of care for everyone in the pool, knowing that some people will be healthier than others. The federal government provided special funds, called r*isk corridor payments*, to insurers during the first

 3. "Preventive Health Care Benefits for Women," Healthcare.gov, accessed 8 June 2017, *https://www.healthcare.gov/preventive-care-women/*.

years of the ACA to help them adjust to this new risk, and many legislators and citizens feel that one "repair" to the ACA would be to continue these subsidies to stabilize markets that have not yet found the right balance.

With their new legislative proposals to replace the ACA, Congressional lawmakers proclaim their guidelines would not to go back to excluding coverage for pre-existing conditions but would allow higher premiums and copays for those who are sick, bringing back medical underwriting. Insurers would also be able to charge an older person up to 500 percent of the premium for a younger person, instead of 300 percent, a 200-percent increase from current law. Alternative legislation to the ACA supports setting up separate pools, policies and pricing for those who are healthy, versus those who are older and disabled/sick. The latter group, those who would be placed in these high-risk pools, could face significant increases in premiums and copays that would essentially exclude them from accessing care.

In the past before ACA, when 35 states implemented high-risk pools, according to Kaiser Family Foundation, federal grants were intermittent and subject to Congressional whim through the appropriations process. The amount appropriated or given to the states for their high-risk pools decreased over time by tens of millions, and these funds made up only between 2 percent and 12 percent of the fund costs.[4] The states had to come up with the rest of the revenue. They decreased costs by capping or closing enrollment in the high risk pools.[5] Returning to high-risk pools could potentially mean that patients may be rejected from qualifying for the pools if states move to decrease cost, which in turn could lead to loss of coverage over time.

Prohibition of Lifetime Limits and Establishment of Out-of-Pocket Maximums

Before the ACA, insurance companies could set a limit on the maximum amount of coverage a person could receive in a lifetime—for example, $1,000,000 worth of care. A $1,000,000 cap may seem like a generous amount, but HIV medications alone can cost more than $36,000 a year, and in 2016, the cost of hepatitis C treatment was between $84,000 and $94,500 for medications alone.[6] Even infants with high medical needs requiring multiple surgeries could incur medical costs over one million dollars in their first year of life.

Under the ACA, health plans are prohibited from instituting lifetime limits on patients and their family members. Moreover, the ACA creates out-of-pocket maximums, or spending limits for individuals and families. In 2017, the out-of-pocket spending limit for a plan purchased on the marketplace is $7,150 for an individual plan or $14,300 for a family plan. This out-of-pocket maximum does not include spending on premiums or expenditures for services not covered by a health plan.

Mental Health Parity

The Affordable Care Act extended the Mental Health Parity and Addiction Equity Act of 2008 to include individual health plans. Before the ACA, parity for behavioral health coverage applied to only group health plans, through employer benefits or employee unions. The concept of *parity* means health plans cannot impose any limits on mental health coverage less favorable than any such limits imposed on medical/surgical benefits. For example, limits on inpatient hospital stays for medical conditions cannot be different from limits for inpatient behavioral health issues, and if the plan has an out-of-network deductible for medical care, the same deductible must exist for out-of-network behavioral health care. This provision has been beneficial for LGBT communities who face disparities in mental and behavioral health coverage.

4. National Association of State Comprehensive Health Insurance Plans (NASCHIP), "Comprehensive Health Insurance for High-Risk Individuals: A State-by-State Analysis," 2011/2012, *http://www.naschip.org*, quoted in Karen Pollitz, "High-Risk Pools for Uninsurable Individuals," *Kaiser Family Foundation Issue Brief,* published February 2017, accessed 8 June 2017, *http://www.kff.org/health-reform/issue-brief/high-risk-pools-for-uninsurable-individuals/*.
5. Karen Pollitz, "High-Risk Pools for Uninsurable Individuals," *Kaiser Family Foundation Issue Brief,* published February 2017, accessed 8 June 2017, *http://www.kff.org/health-reform/issue-brief/high-risk-pools-for-uninsurable-individuals/*.
6. Adam Wenger, "The Cost of Treating HIV: One Man's Monthly Medical Bill," Healthline, published December 2014, accessed 8 June 2017, *http://www.healthline.com/health/hiv-aids/monthly-cost-treating-hiv.*

Prohibitions Against Sex and Gender Discrimination

Section 1557 of the ACA prohibits discrimination in health care based on race, color, national origin, sex, age or disability. The Department of Health and Human Services (HHS), which administers the ACA and is responsible for implementing the law, clarified that sex discrimination included discrimination regarding gender identity and sex stereotype in any health program or health care facility receiving federal funds, extending the reach of Section 1557's effects. With new appointees in HHS overseeing this implementation, concerns have been raised about potential changes in how Section 1557 will be interpreted by the new administration.

Intent and Possible Impact of Section 1557 of the Affordable Care Act

The ACA's Section 1557 nondiscrimination provision is a new and important civil rights paradigm shift for the health care industry. The ACA is the first federal civil rights law ever to focus exclusively on health care nondiscrimination and the first to prohibit discrimination on the basis of sex, defined to include gender identity and sex stereotypes,[7]* in addition to prohibiting discrimination on the basis of race, color, national origin, age, disability and limited English proficiency.

Under Section 1557 regulations, covered health care providers must take immediate action for compliance. For example, if a covered health care provider has 15 or more employees, that provider must …

- designate an employee responsible for coordinating compliance with Section 1557 and the final rule;
- adopt a grievance procedure to promptly and equitably resolve complaints of discrimination;
- and post nondiscrimination notices, which must include language assistance "taglines" translated into the top 15 languages spoken on a statewide basis.[8]

Section 1557's historic prohibition of sex and gender discrimination is interpreted to prohibit different treatment—including different premium pricing—for anyone who is pregnant, able to become pregnant, has had an abortion, is unmarried or who does not meet traditional sex stereotypes.[9]

This anti-discrimination protection applies not just to persons who purchased a policy on the ACA Marketplace, but also to anyone receiving care through Medicaid, Children's Health Insurance Program (CHIP), Medicare or the Veterans Administration (VA) or from any providers who receive federal funds.[10]

Section 1557 clearly addresses transgender discrimination. Prior to the ACA, the majority of health insurance policies "contained exclusions that could deny transgender people coverage for medically necessary care related to gender transition—including hormone therapy, mental health counseling and surgeries—even though the same services and procedures are routinely covered for nontransgender individuals for indications such as endocrine disorders, cancer treatment or prevention or reconstruction following injury."[11]

* ***Note:*** The language "discrimination on the basis, defined to include gender identity and sex stereotypes" is from the ACA's language and cited on HHS's website: https://www.hhs.gov/civil-rights/for-individuals/section-1557/fs-sex-discrimination/index.html.

7. Jennifer Kates, Usha Ranji, Adara Beamesderfer, Alina Salganicoff, Lindsey Dawson, "Health and Access to Care and Coverage for Lesbian, Gay, Bisexual, and Transgender Individuals in the U.S.," *Kaiser Family Foundation Issue Brief*, published November 2016, accessed 8 June 2017, *http://www.kff.org/report-section/health-and-access-to-care-and-coverage-for-lgbt-individuals-in-the-u-s-update-health-challenges/*.
8. Arnall Golden Gregory LLP, Andrew Stevens, "Deaf Individuals Sue Health System for Discrimination Under Section 1557 of the ACA," JDSUPRA®, published 27 March 2017, accessed 8 June 2017, *http://www.jdsupra.com/legalnews/deaf-individuals-sue-health-system-for-15142/*.
9. "Nondiscrimination Protection in the Affordable Care Act: Section 1557" fact sheet, National Women's Law Center resources,, published May 2016, accessed 8 June 2017, *https://nwlc.org/wp-content/uploads/2015/11/General-1557-Factsheet-May-2016.pdf*.
10. Timothy Jost, "HHS Issues Health Equity Final Rule," *Health Affairs* (blog), published 14 May 2016, accessed 8 June 2017, *http://healthaffairs.org/blog/2016/05/14/hhs-issues-health-equity-final-rule/*.
11. Kellan Baker, "LGBT Protections in Affordable Care Act Section 1557," *Health Affairs* (blog), published 6 June 2016, accessed 8 June 2017, *http://healthaffairs.org/blog/2016/06/06/lgbt-protections-in-affordable-care-act-section-1557/*.

Under Section 1557, "private plans and state Medicaid programs cannot limit access to sex-specific services, such as cervical pap tests, mammograms and prostate exams, based on a transgender person's sex assigned at birth, gender identity or recorded gender. For example, a covered entity cannot deny access to treatment for prostate cancer to a transgender woman" or a routine pap smear to a transgender man.[12]
This section also equires covered entities to provide transgender individuals equal access to programs, including facilities, without discrimination and consistent with an individual's gender identity.

As a result of Section 1557, health insurance coverage rules of federal employees were clarified to state: "Effective January 1, 2016, no carrier participating in the Federal Employees Health Benefits Program may have a general exclusion of services, drugs or supplies related to gender transition or sex transformations."[13]

Further, Section 1557 has resulted in all Tennessee marketplace carriers in 2017 offering gender reassignment surgery and ongoing maintenance hormone treatments, if the health criteria developed by the World Professional Association for Transgender Health (WPATH) are met.[14] (See appendix 2.1, which outlines the WPATH criteria adopted by Tennessee insurers.)

Enforcement of Section 1557 Rights in Question

Section 1557 is enforced through the Office for Civil Rights (OCR) in the Department of Health and Human Services (HHS) at the federal level.

In what could become another blow to LGBT health care rights, a lawsuit in Texas that challenged the broad interpretation of Section 1557 in regard to women's reproductive rights has resulted in a court injunction's being imposed on enforcement of Section 1557. This legal action casts doubt on how Section 1557 will be enforced nationally or in states like Tennessee, until this case is resolved.

At the time of publication, the HHS OCR described their enforcement position as follows:

> On December 31, 2016, the U.S. District Court for the Northern District of Texas issued an opinion in Franciscan Alliance, Inc. et al v. Burwell, which placed a nationwide injunction on Section 1557 regulation's prohibitions against discrimination on the basis of gender identity and termination of pregnancy. Accordingly, HHS' Office for Civil Rights (HHS OCR) may not enforce these two provisions while the injunction remains in place. Consistent with the court's order, HHS OCR will continue to enforce important protections against discrimination on the basis of race, color, national origin, age or disability, as well as other sex discrimination provisions that are not impacted by the court's order.
>
> If you believe you have been discriminated against on one of the bases protected by Section 1557, you may file a complaint with the Office for Civil Rights.[15]

Please see appendix 2.2 "What to Do If You Feel You Have Been Discriminated Against by an Insurer or Provider" for more information about the process for filing discrimination complaints.

12. Kellan Baker, "LGBT Protections in Affordable Care Act Section 1557," *Health Affairs* (blog), published 6 June 2016, accessed 8 June 2017, *http://healthaffairs.org/blog/2016/06/06/lgbt-protections-in-affordable-care-act-section-1557/.*
13. U.S. Office of Personnel Management, "Benefits for Lesbian, Gay, Bisexual, and Transgender (LGBT) Federal Employees and Annuitants: A Supplemental Resource," OPM.gov., accessed 8 June 2017, *https://www.opm.gov/policy-data-oversight/diversity-and-inclusion/reference-materials/benefits-for-lgbt-federal-employees-and-annuitants-supplemental-resource-to-webcast.pdf.*
14. World Professional Association for Transgender Health, *Standards of Care,* Version 7, published 2012, accessed 8 June 2017, *https://wpath.org/*.
15. Department of Health and Human Services, "Section 1557 of the Patient Protection and Affordable Care Act," HHS.gov., accessed 5 May 2017, *https://www.hhs.gov/civil-rights/for-individuals/section-1557/.*

Section 3

Impacts of 2017 ACA Marketplace Plans on LGBT Health in Tennessee

Photo Credit: Walter Davis, 2016.

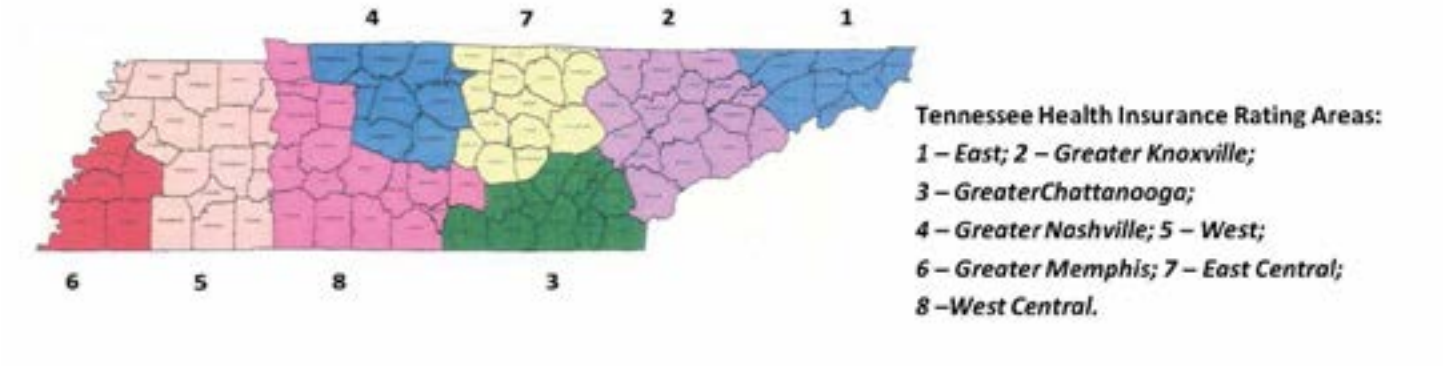
Section 3: Impacts of 2017 ACA Marketplace Plans on LGBT Health in Tennessee

One of the major innovations of the ACA marketplace exchange is its transparency—the ability the marketplace provides consumers to compare the details of coverage and cost among different plans. The marketplace enables side-by-side plan comparisons on the cost of premiums, the ways in which deductibles—the amount that must be paid at the beginning of each year, in addition to the premium, before a person's insurance plan will pick up any portion of the cost—and copayments are set up, the content and pricing of medication formularies and the depth and breadth of provider networks. This aspect of the ACA helped millions of Americans learn how complicated our current system of health insurance truly is and how important it is to examine plans carefully to ensure that they receive the best value for their health care needs.

The marketplace exchanges are set up to guide individuals and families earning between 100 and 400 percent of the Federal Poverty Level (FPL) in understanding their eligibility for federal tax subsidies, which can be taken in advance to reduce the cost of premiums throughout the year. Those with incomes between 100 and 250 percent of FPL are also eligible for reductions in the amount of cost-sharing expected at the point of care. These subsidies and cost-sharing reduction funds, which have been critical for millions of Americans and their families, are threatened by health care "reform" proposals currently under consideration in Congress. (Note: Persons earning less than 100 percent of the FPL were expected to gain health coverage through the states' expansion of their Medicaid programs. Tennessee remains one of 19 states that have refused to expand Medicaid, leaving over 300,000 mostly working adults in the coverage gap, without any options for health insurance. See appendix 3.3: "How Failure to Expand Medicaid Impacts LGBT Health in Tennessee" for more information.)

While some states—for example, Kentucky—developed their own state exchanges with state-specific websites for plan comparison and purchase, Tennessee uses the federal exchange website, also referred to as Healthcare.gov, as their marketplace. Tennessee also is the only state in the nation to also use Healthcare.gov to exclusively determine eligibility for TennCare, the state's Medicaid program. Many Tennesseans have relied on the free one-on-one education and assistance provided by marketplace navigators and volunteer certified application counselors (CACs) to help them through the process of applying for TennCare or insurance plans through federal marketplace. These in-person guides can explain the interplay among plan premium pricing, deductibles and cost-sharing so that consumers can pick plans that best meet their needs and budgets.

While the future of Healthcare.gov and the ACA are far from certain, the following lessons learned can be applied to selecting any private insurance plan or to choosing among options offered by employers.



Factors That Impact the Cost of Coverage Under the ACA

Insurers who offer plans on the ACA exchange must cover the same essential health benefits and must limit their administrative costs to no more than 20 percent, meaning 80 cents of every premium dollar must be spent on claims or on improving health care quality, according to federal law. However, insurers are allowed to vary the price of the premium for the same plan based on three factors. The first factor is the variation in usual and customary health care costs to insurers within a defined geographic area called a rating area. Tennessee's eight rating areas are defined by the Tennessee Department of Commerce and Insurance. Usual and customary costs can be influenced by the rates an insurer negotiates with health systems in their networks, the way providers practice and the seriousness of illness or injury experienced by those enrolled in an insurer's plan. The second factor is the smoking status of the purchaser: smokers can be charged premiums of up to 150 percent of that of a nonsmoker. The third factor is the age of the purchaser. The ACA limits the amount an older person can be charged for premiums to no more than three times what a younger person can be charged.

Table 3.1: Actuarial Levels of ACA Marketplace Plans

"Metal level" of plan	Percentage of cost of care consumer pays on average	Percentage of cost of care insurer pays on average
Bronze	40%	60%
Silver	30%	70%
Gold	20%	80%
Platinum	10%	90%

The ACA marketplaces allow consumers to choose among four actuarial levels of plans named after different metals: *Bronze, Silver, Gold* and *Platinum*. Actuarial value is defined as the percentage of total average costs for covered benefits that a plan will cover when the total premiums and copayments are taken into account. For example, if a plan has an actuarial value of 70 percent, then, on average, the consumer would be responsible for 30 percent of the costs of all covered benefits. If the actuarial value is 90 percent, then the consumer could expect to pay 10 percent of the costs of care. However, in any given year, a plan enrollee could be responsible for a higher or lower percentage of the total costs of covered services, depending on the person's actual health care needs and the type of insurance policy chosen.

Table 3.2: ACA Premium Cap Determination

Income percentage of FPL	Premium cap
< 100%	Not eligible
100–133%	2.04%
133–159%	3.06–4.08%
150–200%	4.08–6.43%
200–250%	6.43–8.21%
250–300%	8.21–9.69%
300–400%	9.69%
Over 400%	No cap

Platinum and Gold plans tend to have the highest monthly premiums but require little or no copay or coinsurance for doctor visits or ER care. This structure tends to benefit people with steady and predictable higher incomes but also higher-than-average need for doctor visits for ongoing care. Bronze and Silver often have lower monthly premiums but charge higher copays for emergency room care, doctor visits and medications. These plans may be more cost effective for younger or healthier persons.

Persons and families earning between 100 and 400 percent of the Federal Poverty Level (FPL) receive premium assistance toward their monthly premium costs, based on a formula that caps total health care premium costs at a reasonable percentage of their total income (see table 3.2). Premium assistance under the ACA, in the form of tax subsidies, can be used in advance to purchase any plan, but the amount of the subsidy is calculated on the cost of the second-lowest-priced Silver plan available in the rating area. Individuals or families earning under 250 percent of FPL, defined in table 3.3, are also eligible for additional cost-sharing reductions (CSRs)* but only if they purchase a Silver plan. The difference between the actual cost-sharing amounts built into the plan and the reduced cost sharing for a low-income consumer are supposed to be paid back to the insurer by the federal government.[1]

Table 3.3: Federal Poverty Level (FPL) Guideline 2017

Family size	100%	250%	400%
1	$12,060	$30,150	$48,240
2	$16,240	$40,600	$64,960
3	$20,240	$50,600	$80,960
4	$24,600	$61,500	$98,400
5	$28,780	$71,950	$115,120
6	$32,960	$82,400	$131,840

ACA marketplace plans also set a ceiling on how much any one individual or family must pay yearly for their health coverage. This out-of-pocket maximum (OOPM)—which does *not* apply to premiums or spending for nonessential health benefits—was $7,150 for an individual and $14,300 for a family earning over 250 percent in 2017. (Note: OOPMS may differ for plans linked to health savings accounts [HSAs].)

Of the over 234,000 Tennesseans who chose marketplace plans in 2017, 85 percent qualified for premium subsidies in 2017, by earning under 400 percent of FPL, and 57 percent received both premium subsidies and cost-sharing reductions for Silver plans, by earning under 250 percent of FPL. As noted in the introduction to this report, approximately one-third of LGBT persons and households in Tennessee earn under 250 percent FPL and can benefit from both of these subsidies.

Catastrophic health plans are also available for persons under 30 or persons of any age with a hardship exemption such as bankruptcy; loss of home; death of a family member wage-earner; victim of domestic violence;or victim of fire, flood, tornado or other natural disaster or with an affordability exemption (cost of insurance offered by marketplace or employer is more than 8.13 percent of income [2017]). Premium tax credits *cannot* be used to help pay for catastrophic plans, which have low premiums but high deductibles. The deductible for catastrophic plans in 2017 was the full OOPM of $7,150.

Impact of Subsidies and Competition on the Cost of Coverage

To illustrate how tax subsidies and cost-sharing reductions make a difference for lower-income Tennesseans, the report's authors compared Silver plans offered for 2017 by each of the carriers. Cigna and Humana plans designated as standardized simple choice plans on the ACA marketplace were chosen. Simple choice plans are new on the federal marketplace this year and were meant to provide a way of countering the movement toward higher and higher deductible plans. Simple choice plans limit deductibles to around $3,500 and have OOPM capped at about $7,100. Services such as preventive care and mental health services need to be exempt from the deductible payment to earn the designation simple choice. Blue Cross Blue Shield of Tennessee (BCBST) did not offer a simple choice plan, so the BCBST plan with a premium amount closest to the simple choice plans' premiums was selected for comparison.

* ***Note:*** Members of the Congressional GOP sued the Obama administration over CSRs, saying that the administration could not issue to insurers any payment not appropriated by Congress. The new HHS secretary is now linked to that unresolved suit. For more information, see this source at The Commonwealth Fund.

Using the Healthcare.gov Preview of 2017 Plans and Prices tool, a single 28-year-old nonsmoker earning $20,000 per year—168 percent of FPL for 2017—was used as a hypothetical consumer. Costs were calculated for a selected plan in each of the rating areas, based on the consumer's attributes, holding age and smoking status constant. Table 3.4 of these calculations reflects variation in plans and differences in the cost of care and/or the price of the Silver plan with the second-lowest premium amount, the benchmark used to assess the amount of the subsidy in each area.

Note: Appendix 3.1 shows more detail on the number of carriers and plans offered in each rating area. Appendix 3.2 provides a similar analysis for a 60-year-old person earning $20,000.

As noted previously, cost of care depends on the usual and customary health care costs in a rating area and with the complexity of health care needed by persons living in that rating area. The healthier the people in a rating area's risk pool, the lower the average costs the insurer may have to cover per person, and therefore, the lower the premiums should be. The more hospitals and providers in a rating area, the more likely an insurer can negotiate a strong network at competitive rates. The more insurers offering plans in a rating area, the more likely it is that those insurers will design plans of higher value and price their plans to attract consumers to choose their plans over their competitors'.

In 2014, five insurers participated in Tennessee marketplaces; in 2017, only three insurers did. This loss of insurers from ACA marketplaces is not happening in every state and cannot be attributed to solely the basic structure of the ACA. Indeed, supporters of the ACA argue that the withdrawal of insurers from the marketplace is due more to decisions in Congress and state governments. The persistent efforts by Congress to repeal the ACA without a clear replacement option and legal challenges that threaten risk adjustment and cost-sharing reduction payments to insurers, have caused understandable uncertainty among insurers.[2] States like Tennessee, which failed to expand their Medicaid programs to address the health and mental health needs of low-income adults, experienced more problems keeping insurers in their individual markets and lost billions of federal dollars that could have been invested back into in their health systems. (See appendix 3.3: "How Failure to Expand Medicaid Impacts LGBT Health in Tennessee.") States with stronger insurance regulation laws than Tennessee's successfully used that state-level regulatory authority to keep their exchanges more competitive.[3]

The Tennessee Department of Commerce and Insurance (TDCI) has been deeply concerned over the competitive financial health of the three remaining Tennessee marketplace insurers: Cigna, Humana and BCBST. TDCI granted these insurers some of the highest premium increases in the nation last year.[4] While these high premium increases were intended to keep the insurers in the marketplace, they forced many Tennesseans who were not eligible for premium assistance—those earning over 400 percent of FPL—out of the federal marketplace and into commercial individual markets where lower cost, high deductible options, catastrophic coverage, and temporary coverage options are more available.

Despite receiving a 62-percent premium increase for 2017, BCBST withdrew at the last minute from all three major urban rating areas—Memphis, Nashville and Knoxville—for 2017. Currently only three rating areas in Tennessee—East, Greater Nashville and Greater Memphis—have plans offered by two carriers. Five rating areas have just one carrier offering plans. The 16 counties in the Greater Knoxville rating area have only

2. Seth Chandler, "Judge's Ruling of 'Risk Corridors' Not Likely to Revitalize ACA." *Forbes: The Apothecary,* published 13 February 2017, accessed 9 June 2017, *https://www.forbes.com/sites/theapothecary/2017/02/13/judges-ruling-on-risk-corridors-not-likely-to-revitalize-aca/#3336d61277fe.* Larry Levitt L, Cynthia Cox, Gary Claxton, "The Effects of Ending the Affordable Care Act's Cost-Sharing Reduction Payments," Kaiser Family Foundation, published 25 April 2017, accessed 9 June 2017, *http://kff.org/health-reform/issue-brief/the-effects-of-ending-the-affordable-care-acts-cost-sharing-reduction-payments/.*
3. Cynthia Cox, Ashley Semanskee, Gary Claxton, Larry Levitt, "Explaining Health Insurance Reform: Risk Adjustment, Reinsurance, and Risk Corridors," Kaiser Family Foundation, published 17 August 2016, accessed 9 June 2017, *http://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors/.*
4. Louise Norris, "Tennessee Health Insurance Marketplace: History and News of the State's Exchange," *HealthInsurance.org*™, published 12 April 2017, *https://www.healthinsurance.org/tennessee-state-health-insurance-exchange.*

Humana, and BCBST was the sole provider in the remaining 57 counties in Greater Chattanooga, West, West Central and East Central. Humana has been threatening to leave the marketplace in 2018, which would leave the Greater Knoxville rating area with no insurer at all.[5] As of this report's printing, BCBST has signaled it might re-enter the Greater Knoxville rating area.

In markets without competition and without strong consumer regulation, insurance carriers have more leeway to control the price of their premiums, including the cost of the premium for the second-lowest priced Silver plan in each rating area. As table 3.4 illustrates, the higher this Silver plan premium, the higher the amount of premium subsidies that low-income consumers—and ultimately their insurers—receive from the federal government.[6] This difference can be significant.

Table 3.4 Statewide Variations in the Cost of Selected Health Care Plans among Rating Areas Based on Calculations provided by Healthcare.gov Preview of 2017 Plans and Prices

Rating Area	Silver Plan selected for comparison	Subsidized annual premium calculated for selected plan for 28 yr old earning $20,000/year (168% FPL)	Premium tax subsidy for 28 year old earning $20,000/year (168% FPL)	Estimated OOPM for 28 year old earning $20,000/year (168% FPL)	Estimated total yearly cost of health care for 28 year old earning $20,000 (premium + OOPM)	Full annual premium price of selected plan for a 28 year old not eligible for subsidy (earns >400% FPL)	Full annual premium price of benchmark (second lowest) Silver Plan for 28 year old not eligible for subsidy (earns >400% FPL)
1	Cigna 3500/700***	$1,692	$2,964	$2,000	$3,692	$4,659	$3,956
	BCBST S04S***	$1,701	$2,964	$1,600	$3,301	$4,668	
2	Humana 3550/900*	$988****	$3,264	$2,050	$3,038	$4,258	$4,258
3	BCBST S04S**	$28	$5,136	$1,600	$1,628	$5,166	$6,127
4	Cigna 3500/700***	$1,749	$3,288	$2,000	$3,749	$5,038	$4,278
	Humana 3550/900***	$1,814	$3,288	$2,050	$3,864	$5,103	
5	BCBST S04S***	$0	$5,352	$1,600	$1,600	$5,346	$6,339
6	Cigna 3500/700***	$1,728	$3,264	$2,000	$3,728	$4,989	$4,250
	Humana 3550/700***	$1,084	$3,264	$2,050	$3,134	$4,345	
7	BCBST S04S**	$116	$4,584	$1,600	$1,716	$4,695	$5,568
8	BCBST S04S**	$0	$5,364	$1,600	$1,600	$5,361	$6,357

*Benchmark Silver plan in the Rating Area (second lowest priced premium) . **Lowest priced Silver Plan in the Rating Area.
***Plan with premium priced above the benchmark Silver Plan. ****Amount that the premium for the second lowest Silver Plan would cost a 28 year old earning $20,000 in any of the Tennessee Rating Areas.

In addition to the premium subsidy, individuals earning under 250 percent of FPL also qualify for additional cost-sharing reductions that lower the amount of out-of-pocket costs. The cost-sharing amounts for provider or emergency room visits or medications are less for persons earning under 250 percent of FPL than for persons earning over 250 percent of FPL. The OOPM for persons or families earning below 250 percent of FPL is also reduced based on ability to pay. For example, the hypothetical 28-year-old consumer earning under 200 percent of FPL would have an OOPM reduction from $7,150 to the $2,000 range—or for a family, from $14,300 to $4,700. If that 28-year-old earned between 200 and 250 percent of FPL, the OOPM would be lowered from $7,150 to $5,700—or for a family, from $14,300 to $11,400. These reductions are linked

5. Louise Norris, "Tennessee Health Insurance Marketplace: History and News of the State's Exchange," *HealthInsurance.org*™, published 12 April 2017, *https://www.healthinsurance.org/tennessee-state-health-insurance-exchange.*
6. Cynthia Cox, Michelle Long, Ashley Semanskee, Rabah Kamal, Gary Clxton, Larry Levitt, "2017 Premium Changes and Insurer Participation in the Affordable Care Act's Health Insurance Marketplaces," Kaiser Family Foundation, published 1 November 2016, accessed 9 June 2017, *http://kff.org/health-reform/issue-brief/2017-premium-changes-and-insurer-participation-in-the-affordable-care-acts-health-insurance-marketplaces/.*

to poverty level and are consistent across rating areas. As noted earlier, the ACA makes up for the difference due to subsiding cost-sharing reductions, through direct reimbursement payments to insurers.[7]

Impact of Plan Design on the Cost of Coverage

The design details of the plans themselves can vary in multiple ways. Examples of these variables are how an individual needs to pay for their financial share of their care: high or low monthly premium, high or low deductible at the beginning of each year or high or low proportion of the costs at the time the care is needed. Plans also differ in the number and geographic distribution of the health providers a person can chose from. This section shows examples of how these variations impact LGBT consumers' costs and access.

Table 3.5: Example of Differences in Plan Formulary Tiers

Medication deductible (amount that must be met before plan will pick up a portion of the medication cost)	CIGNA Included in plan deductible of $3,500	HUMANA Medication deductible of $500, separate from plan deductible of $3,550	BCBST Included in plan deductible $2,000
Medication tiers	**In network only**	**In network**	**In or out of network**
1	$10/30-day supply after plan deductible met	$10 per fill; deductible waived	50% after deductible, whether in or out of network
2	$15/30-day supply after plan deductible met	$20 per fill; deductible waived	50% after deductible, whether in or out of network
3	$50/30-day supply after plan deductible met	$50 per fill after medication deductible met	50% after deductible, whether in or out of network
4	$100/30-day supply after plan deductible met	50% after medication deductible met	50% in network; out of network not covered
5 (usually with special authorization)	40% with preauthorization after plan deductible met	40% after medication deductible met, if preferred provider used	n/a

Although the ACA provision establishing the OOPM put an upper limit on what a consumer would pay in addition to their premiums, most individuals with relatively good health would seldom reach those maximums. However, for LGBT individuals with conditions such as HIV infection, the cost of medications alone could easily push an enrollee's medical expenses to the upper limit of an annual cap within several months.

For the past several years of open enrollment in the ACA, Nashville CARES has worked with the Center for Health Law and Policy Innovation (CHLPI) at Harvard Law School to do extensive review of the plans offered through the federal marketplace for Tennesseans to illustrate relative costs of hepatitis C and HIV medications. These studies found that insurers placed all HIV medications in their formularies at the highest cost tier that also required the highest coinsurance payments at purchase. A formulary is a list of the drugs each plan covers. Every covered medication is assigned to a tier. Such deliberate "adverse tiering" can be used to deter "undesirable" consumers—persons with expensive-to-treat health conditions—from enrolling on their plans. Nashville CARES joined CHLPI in successful legal challenges to the pricing of these lifesaving medications by Tennessee insurance carriers. The tiering structures for Cigna and Humana described here is responsive to these challenges and is more affordable than in years past. (For current information, please see CHLPI 2017 Plan Analysis for Qualified Health Plans: Tennessee.[8])

7. Larry Levitt, Cynthia Cox, Gary Claxton, "The Effects of Ending the Affordable Care Act's Cost-Sharing Reduction Payments," Kaiser Family Foundation, published 25 April 2017, accessed 9 June 2017, *http://kff.org/health-reform/issue-brief/the-effects-of-ending-the-affordable-care-acts-cost-sharing-reduction-payments/* and Matthew Rae, Gary Claxton, Larry Levitt, "Impact of Cost Sharing Reductions on Deductibles and Out-of-Pocket Limits," Kaiser Family Foundation, published 22 March 2017, accessed 9 June 2017, *http://kff.org/health-reform/issue-brief/impact-of-cost-sharing-reductions-on-deductibles-and-out-of-pocket-limits/*.
8. Center for Health Law and Policy Innovation, *2017 Plan Analysis for Qualified Health Plans: Tennessee*, Harvard Law School, published December 2016, accessed 9 June 2017, *http://www.chlpi.org/plan-assessment/*.

Table 3.5 illustrates, for the same Silver plans as in table 3.4, how each of the Tennessee insurers on the marketplace—Cigna, Humana and BCBST—structures their medication formularies and medication cost sharing differently. The tiers are usually based on cost of the medication, but cost effectiveness of the medication can be another consideration. Almost all medications are subject to a copayment, a set amount of money that must be paid to a pharmacy each time a prescription is filled, or coinsurance, usually a percentage of the actual cost of the medication.

In the compared plans, both Cigna and BCBST apply the full plan deductible amount to medications. This practice means that the full amount of every medication needs to be paid in full by the consumer until the plan deductible amount is paid. For the Cigna 3500 plan, the deductible is $3,500. For the BCBST S04S plan, the deductible is $2,000.

The Humana 3550 plan offers a separate medication deductible of $500. After that amount is paid, Humana will pick up a portion of each medication cost based on the copayments associated with its tier. For less expensive medications, assigned to tier 1 and tier 2, this Humana plan waives the deductible altogether so that the consumer can immediately start paying just the tier 1 ($10/month) or tier 2 ($20/month) cost, rather than the full price. However, a separate $3,550 plan deductible for provider visits, labs, procedures and so forth must be met too.

Table 3.6 (see page 34) uses the hypothetical 28-year-old LGBT person but with changed characteristics: one who earns above 250 percent of the FPL and does not receive cost-sharing reductions. Suppose that this person needs two HIV medications and ongoing hormone replacement treatment. And suppose that the person in this scenario scheduled their annual well-adult full physical with their primary care provider in January and a visit to their infectious disease specialist later in March. The table shows how expenses would differ under each of the plans from January through March.

These differences in the way these plans structure cost-sharing for medications illustrate the importance for consumers to seek better value in plan design. While persons with different health care needs may look for different types of plans, most consumers can agree on some elements of plan design.

For example, cost-sharing requirements for care that is known to be effective should be lower or eliminated to encourage that kind of care. This rationale is behind the ACA's requirement that there be no copayments for annual well-adult or well-child examinations and that recommended vaccines should be available for no additional copayment (see section 2). There should be no cost-sharing required for medications essential for controlling chronic conditions—for example, insulin for persons with diabetes, rescue inhalers for people with asthma or epinephrine injectors for persons with fatal bee allergies. Likewise, in a high value plan, there should be no cost sharing for doctor's visits needed to properly manage chronic conditions, such as foot exams or eye exams for persons with diabetes or viral load monitoring lab tests for HIV infection. Several states took the initiative to pass laws or issue regulations to require commercial health plans to adopt such value-based designs.[9] High value plan legislation has not been introduced in Tennessee yet, but a similar law could be a proposal that advocacy groups may employ in the future.

Adequacy of Provider Networks and Access to Specialty Care

Another important aspect of the consumer protections provided by the ACA is that health insurers must provide access to provider directories so that consumers can choose their primary care providers and check that the specialists they need are in network. In-network provider services are usually covered at much more reasonable rates than services that patients seek from out-of-network providers.

9. Lydia Mitts, "What Is VBID (Value Based Insurance Design)?" Families USA, published July 2016, accessed 9 June 2017, *http://familiesusa.org/product/slideshow-what-vbid-value-based-insurance-design.*

Table 3.6: Variation in Monthly Cost of Medications Due to Differences in Payment Structure in Silver Plans Compared												
Plans	**CIGNA Connect 3500**				**Humana 3550**				**BCBST**			
DEDUCTIBLE that must be met before medication copays or coinsurance begins, if no cost-sharing assistance available to consumer	**$3,500.00**				**$500.00 with waiver of tier 1 and tier 2 medications for meds; $3,550.00 for nonmedication plan expenses**				**$2,000.00**			
Medication and typical monthly cost	**Tier**	**January**	**February**	**March**	**Tier**	**January**	**February**	**March**	**Tier**	**January**	**February**	**March**
lamivudine tablet or Epivir® — 150 mg ($168.37)	2	$168.37	$168.37	$15.00	2	$20.00	$20.00	$20.00	1	$168.37	$133.37	$84.19
emtricitabine/ tenovir disoproxil fumarate or Truvada® ($1,517.77)	3	$1,517.77	$1,514.95	$50.00	3	$550.00	$50.00	$50.00	3	$1,517.77	$758.89	$758.89
injectable testosterone cypionate ($16.35)	2	$16.35	$15.00	$15.00	2	$20.00	$20.00	$20.00	1	$16.35	$8.18	$8.18
leuprolide acetate or Lupron Depot® ($164.19)	2	$164.19	$15.00	$15.00	2	$20.00	$20.00	$20.00	4	$164.19	$82.10	$82.10
Total month's out of pocket medication cost		**$1,866.68**	**$1,713.32**	**$95.00**		**$610.00**	**$110.00**	**$110.00**		**$1,866.68**	**$982.84**	**$933.36**
Total out-of-pocket costs for 3 months of medications	***$3,675.00***				***$830.00***				***$3,782.58***			
Cost of annual primary care well-adult visit in January	0 for annual well-adult visit, under ACA				0 for annual well-adult visit, under ACA				0 for annual well-adult visit, under ACA			
Cost of annual infectious disease specialist visit in March	$60.00 per specialty physician visit + 20% of lab fees, since plan deductible of $3,500.00 already met				100% of total visit until plan deductible of $3,550.00 met; then $40.00 per visit and 20% of lab fees				50% of total visit cost until plan deductible met			
Purple shading indicates when deductible is met and when plan cost-sharing formulas are applied.												

As table 3.7 shows, BCBST covers only 50 percent of the cost of in- or out-of-network care; Humana, only 30 percent of the cost; and Cigna will not cover ANY of the cost of out-of-network care. The ACA requires that the in-network annual well-adult exam has no coinsurance or copay and that all necessary emergency medical care, whether provided by an in-network or out-of-network provider, is covered at in-network rates. However, as explained below, these rates may not always apply to emergency department "support" services such as radiology or anesthesiology.

All insurers on the marketplace must provide a link to an online provider directory that can be sorted by specialty and location. Some directories provide additional access to information on a provider's certifications and awards. Some listings are kept more up-to-date than others. For example, one Tennessee insurer's list included names of providers who had transferred out of the state more than three years ago, and another's directory tended to inflate the number of providers available by counting each location where a clinician practiced as a separate clinician.

Network adequacy refers to a variety of factors that assure a consumer is able to get the care they need. These factors include the ratio of available primary care providers and specialists to the number of

Table 3.7: Cost of In-Network Versus Out-of-Network Care After Deductible Is Met			
Service	Cigna	Humana	BCBST
Visit to in-network primary care provider for sick visit	$30.00	$20.00	50% of charges
Visit to out-of-network primary care provider for sick visit	Full charge	70% of charges	50% of charges
Visit to in-network specialist	$65.00 (referral required)	$40.00 (no referral required)	50% of charges
Visit to out-of-network specialist	Full charge	70% of charges	50% of charges

insured persons in a rating area, the variety of specialists available to meet the varied health care needs of a population, the geographical distance a person needs to travel to get to needed care, the waiting times that a person faces before they can get an appointment and the hours health care facilities are open. Network adequacy is a special concern to many persons who are LGBT, because of special health and behavioral health care needs and because few currently practicing health care providers have received specific clinical and cultural training on LGBT health.

Providers who graduated from medical training programs prior to 2000 may have had limited, if any, specific training on LGBT health care needs, and specific formal training is still very limited. In 2006, the Gay and Lesbian Medical Association (GMLA) published *Guidelines for the Care of Lesbian, Gay, Bisexual and Transgender Patients*[10] to encourage providers to take positive steps towards promoting the health of their LGBT patients. In 2007, *The Fenway Guide to LGBT Health* became the first medical text book focused solely on health care needs of LGBT individuals. It is now in its second edition.[11] As recently as 2011, a survey of deans of medical education of 176 schools of medicine and osteopathy found that the median time spent in teaching content related to LGBT health in the full course of the medical curriculums was 5 hours.[12] One-third of the schools reported that no LGBT content was included in the curriculum. The Association of American Medical Colleges only as recently as 2014 released guidelines for training providers to care for persons who are lesbian, gay, bisexual, transgender, gender-nonconforming or born with differences of sex development.[13]

In conducting this study, THCC and PFLAG-Nashville learned that insurers on the marketplace had no system in place for verifying whether a provider was trained in LGBT health or was welcoming of LGBT persons in their practice. Cigna did refer to a "welcoming provider" list maintained by GLMA: Health Professionals Advancing LGBT Equality,[14] but only 20 providers were listed for the entire state. The list did not indicate what insurance plans these clinicians accept. Some online directories enable providers to list areas of special interest and additional certifications, but LGBT care was rarely mentioned. Study analysts inquired of each health insurance company whether they would provide any assistance to LGBT consumers in finding trained and welcoming providers. BCBST and Cigna responded by saying they did not provide that service but would want to be informed if a consumer was turned away or felt discriminated against by a provider. Humana never responded to this inquiry.

10. Gay and Lesbian Medical Association (GMLA), *Guidelines for Care of Lesbian, Gay, Bisexual and Transgender Patients,* published 2006, accessed 9 June 2017, *http://www.rainbowwelcome.org/uploads/pdfs/GLMA%20guidelines%202006%20FINAL.pdf.*
11. Harvey J. Makadon, Kenneth H. Mayer, Jennifer Potter, Hilary Goldhammer, *Fenway Guide to Lesbian, Gay, Bisexual, and Transgender Health, 2nd Edition,* (American College of Physicians, 2017), accessed 9 June 2017, https://store.acponline.org/
12. J. Obedin-Mailver, E. S. Goldsmith, L. Stewart, W. White, E. Tran, S. Brenman, M. Wells, D. M. Fetterman, G. Garcia, M. R. Lunn, "Lesbian, Gay, Bisexual, and Transgender-Related Content in Undergraduate Medical Education." *JAMA®* 306, no. 9 (2011): 971–977, accessed 9 June 2017, *https://www.ncbi.nlm.nih.gov/pubmed/21900137*.
13. Andrew D. Hollenbach, Kristen L. Eckstrand, Alice Dreger, eds., *Implementing Curricular and Institutional Climate Changes to Improve Health Care for Individuals Who Are LGBT, Gender Nonconformng, or Born with DSD: A Resource for Medical Educators,* (Association of American Medical Colleges, 2014), accessed 9 June 2017, *https://www.aamc.org/download/414172/data/lgbt.pdf.*
14. Gay Lesbian Medical Association Provider Directory, *https://glmaimpak.networkats.com/members_online_new/members/dir_provider.asp*

Table 3.8: Number of In-Network Providers Within 15-Mile Radius of Randomly Selected Zip Codes in Greater Nashville Rating Area 4

Provider type	Cigna	Cigna	Humana	Humana
Zip code	37211	37184	37211	37184
Primary care provider — physician in family practice or internal medicine	199	9	266	16
Primary care provider — nurse practitioner or physician assistant	62	12	15	6
Infectious disease specialist	11	1	11	1
Endocrinologist	16	*	19	**
Psychiatrist	9	4	57	5
Psychologist	15	*	55	*

* Consumer would need to travel more than 30 miles to find in-network providers.
** Consumer would need to travel over 50 miles to find in-network providers.

Although provider directories did not allow searches for specialists in LGBT health, an attempt was made to look at the choice among provider networks for primary care providers, whom everyone needs; specialty care in infectious disease (HIV care); endocrinology (hormonal treatment); and behavioral health. For each rating area, one or two random zip codes were chosen and searched for the number of providers in each of the above categories within a 15-mile radius. If no providers were located within a 15-mile radius, the search was extended to 25 miles, then 30, and so forth.

As noted earlier, in 2017, only three rating areas—Greater Nashville, Greater Memphis and East—had two insurance providers. Table 3.8 illustrates the variation in geographical access to providers within the Greater Nashville rating area for two randomly selected zip codes: 37211, a neighborhood of metropolitan Nashville, and 37184, a more rural area outside of Davidson County. The variance illustrated above was similar to observed variance in other metro rating areas.

It is not uncommon in rural rating areas for persons to need to travel up to 50 miles—as the crow flies, not as the roads curve—in order to reach in-network specialists and behavioral health providers, even though an out-of-network provider may be closer. In their marketplace plans, BCBST, which offers plans mainly in rural areas of the state, covers only 50 percent of the charges for primary care sick visits or specialty visits, regardless of whether a provider is in-network or out-of-network.

While the ACA did not specify geographic network adequacy, Medicare Advantage plans and several states have developed time and distance standards. For example, if a person needed to travel over 60 miles or 1.5 hours to get to an in-network provider but an out-of-network provider was within their own community, such standards would require the insurer to apply the in-network rate for that consumer's necessary out-of-network care. Although the majority of counties in Tennessee are rural and Tennessee has witnessed

more rural hospital closures than any other state in the nation,[15] the state does not have such a geographic network adequacy standard in place.

In urban areas, although a larger number of specialists may exist, many are often affiliated with a large group practice or medical center. If the facility chooses to not join or to withdraw from a particular insurer's network, the availability of specialists can change abruptly. This happened in 2016, when BCBST pulled out of most urban rating areas. Vanderbilt University Medical Center had been in the BCBST network but did not take any other marketplace plans in 2017. This decision impacted patients with HIV/AIDS who had relied on Vanderbilt for their specialty care for decades. Thankfully, Nashville CARES was able to negotiate an agreement with an off-market carrier to enable former BCBST marketplace plan members to continue their specialty care with Vanderbilt providers. Without that intervention, these patients would have had long-standing, life-sustaining treatment relationships disrupted.

As noted earlier, the ACA requires that necessary emergency medical services be billed at in-network rates. However, this is not the case for elective surgeries. The authors also examined whether persons could find in-network anesthesiologists, radiologists and emergency room physicians. These specialists, particularly in rural areas of the state, are sometimes contracted by hospitals and are not considered to be on staff. Therefore, even if a hospital is in network and subject to the in-network billing arrangements in a person's health plan, the costs of the contracted services would be considered out of network and billed at full price to the consumer. This practice is called *balance-billing*. Several rating areas—rating areas 5 and 6 and rural sections of rating area 1 and 4—have places where consumers need to travel over 25 miles to find radiologist or anesthesiologist in network. Charges could mount up for consumers needing elective surgery if they were not aware the radiologist or anesthesiologist at the facility providing their care was considered out of network, even though their surgeon was in network. Several states have developed legislation to protect consumers against this type of profitable balance billing. Tennessee has no such protections in place.

The National Association of Insurance Commissioners (NAIC) has developed model state legislation for managing network access and adequacy.[16] This legislation suggests network adequacy is achieved when health carriers "maintain a network that is sufficient in numbers and appropriate types of providers, including those that serve predominantly low-income, medically underserved individuals, to assure that all covered services to covered persons, including children and adults, will be accessible without unreasonable travel or delay." If a specialty provider is not in network to provide a needed covered service, the model legislation would require that the carriers "have a process to assure that a covered person obtains a covered benefit at an in-network level of benefits." The legislation also standardizes provider directories and suggests periodic auditing to guarantee adequacy. This model legislation has not yet been proposed in Tennessee.

Conclusion

The reach of Medicaid, lack of transparency in assessing cost of health insurance plans by providers, financial costs of medication and geographic network adequacy are all factors in whether or not a portion of LGBT Tennesseans can access appropriate health care for their needs. Changes to current health policy can affect these factors and have ramifications on the health or health access of LGBT Tennesseans.

15. Amy Goldstein, "In the Tennessee Delta, A Poor Community Loses Its Hospital—And Sense of Security," *The Washington Post*, published 11 April 2017, accessed 9 June 2017, *https://www.washingtonpost.com/*.
16. National Association of Insurance Commissioners, "Health Benefit Plan Network Access and Adequacy Model Act (Model 74)," Model Regulation Service—4th Quarter 2015, accessed 9 June 2017. *http://www.naic.org/store/free/MDL-74.pdf.*

Section 4

Recommendations for Improving LGBT Health Equity in Tennessee

Photo Credit: Walter Davis, 2016.

Section 4: Recommendations for Improving LGBT Health Equity in Tennessee

Encourage welcoming health care providers to reach out to LGBT clients.

Health care providers play an important role in addressing health disparities for LGBT Tennesseans. Below are some recommendations to stimulate conversation and action.

- Create welcoming and safe environments for LGBT patients by displaying equality symbols in waiting areas and LGBT health literature in exam rooms. Literature is available from national LGBT health organizations such as the Fenway Institute and GLMA and through local organizations such as Nashville Cares and the Program for LGBTI Health at Vanderbilt University Medical Center. (Please see "Section 5: Resources" for additional information.)
- Add questions on sexual orientation and gender identity to patient intake forms. Disclosing sexual orientation and gender identity may lead to better patient encounters and may help providers make patient-centered recommendations for LGBT patients. Appendices 1.1 and 1.22 include sample questions on ascertaining sexual orientation and gender identity recommended by LGBT researchers.[13]

Improve training opportunities across the state for health providers to learn about the special health care needs of the lesbian women, gay men, bisexual men and women and transgender men and women in their communities.

- Encourage advocates to work with Tennessee medical professional organizations and schools of medicine, osteopathy, nursing, physician assistants, pharmacy, PT/OT, counseling and other programs to encourage integrations of LGBT clinical care and cultural sensitivity into regular and continuing education curricular offerings.
- Encourage inclusion of LGBT and LGBT ally representation on advisory boards of health departments and hospitals to raise awareness of need for additional training.

Insure adequacy of trained health providers in approved health insurer networks to meet the needs of LGBT populations.

- Encourage passage of network adequacy legislation that would enable TDCI to enforce the provision that if there were no in-network primary care, specialty, or behavioral health providers trained in addressing special health needs of LGBTQI populations within reasonable proximity, that LGBT consumers could access out-of-network providers at in-network rates.
- Work with insurance carriers to develop registries of providers who do have special training and interest in working with LGBT populations.

Encourage LGBT and health advocacy organizations to develop a system for reporting and investigating claims of health care discrimination related to sexual orientation and gender identity.

- In anticipation of federal and state officials' continuing to ignore or reverse anti-discrimination policies put in place by the ACA, work together to establish a consistent process for documenting and investigating complaints by Tennessee citizens against insurers or providers.
- Continue to work with civil rights organizations such as ACLU and Lambda Legal to identify cases that can test the legality of discriminatory regulations and legislation.

Strengthen coalitions across the state to defeat legislation that discriminates against LGBT populations and to pass legislation that improves access for all Tennesseans to comprehensive quality care.

- Expand opportunities to educate health and mental health advocates about LGBT health needs and to educate LGBT advocates about health care policy and value-based care.
- Consider introduction of NAIC Health Benefit Plan Network Access and Adequacy Model Act in the 2018 session of the Tennessee General Assembly.

Organize inclusive consumer advocacy groups across the state to demand better value and transparency in the health care plans offered in Tennessee, on and off the marketplace.

- Encourage development of a consumer engagement council for the Tennessee Department of Commerce and Insurance to advise the department on consumer needs.
- Continue to monitor the impact of efforts to dismantle the ACA and roll back funding for TennCare and hold decision-makers accountable for the negative impact on individuals, families and communities.

Section 5

Resources on LGBT Health Care and Caring

Photo Credit: Walter Davis, 2016.

Section 5: Resources on LGBT Health Care and Caring

Help Connecting to Health Coverage

Tennessee Health Care Campaign (THCC) was founded in 1989 as Tennessee's first consumer-led advocacy organization for affordable, accessible and accountable health care for all Tennesseans. With the passage of the ACA, THCC also took on the work of organizing and training volunteers across the state to provide unbiased and free support to persons enrolling in ACA plans. THCC brought in OUT2ENROLL to conduct statewide education about the health needs of LGBT populations for Navigators and volunteer assisters. THCC now sponsors a toll-free hotline for Get Covered Tennessee that is answered by volunteers who can connect persons across the state of Tennessee needing health coverage to free local assistance in applying for ACA or TennCare coverage. The number to reach a volunteer at THCC to be connected to enrollment or other health insurance assistance is 844-644-5443.
http://www.thcc2.org/

Health Assist at Family and Children's Services (FCS) operates a program called Health Assist that connects Tennesseans with access to low- and no-cost community-based health care resources, including medical, dental, vision, prescriptions, mental health and substance abuse treatment. Call 800-269-4038 (English), 800-254-7568 (Spanish) or 877-652-3046 (Arabic). FCS is also a partner with THCC in Get Covered Tennessee and assists with outreach, education and enrollment in ACA plans.
http://www.fcsnashville.org/programs/access-to-healthcare

Nashville CARES offers people living with HIV/AIDS and their families a unique combination of services, resources and referrals to help with the challenges of the disease. All services are based upon need regardless of ability to pay. Nashville CARES provides education and testing for HIV, as well as case management for those with HIV infection. Nashville CARES administers programs that enable persons across the state of Tennessee with HIV/AIDS to gain access to comprehensive health, prescription and dental coverage.
http://www.nashvillecares.org/

Tennessee Justice Center is a nonprofit law firm that works with persons on Medicaid/TennCare, Families First and Food Stamps to ensure that they are getting the health care and other benefits that they are entitled to receive in ways that are equitable and non-discriminatory. If you have questions about eligibility for benefits or fair treatment under these programs, you can contact TJC at 877-608-1009.
https://www.tnjustice.org

State Health Insurance Assistance Program (SHIP) provides free and objective outreach, education and enrollment assistance for Medicare insurance and related benefits to help seniors select the best Medicare products for their situation. Contact the SHIP program at 877-801-0044.
https://www.tn.gov/aging/topic/ship

National Resources on LGBT Health

Fenway Institute's National LGBT Health Education Center provides educational programs, resources and consultation to health care organizations with the goal of optimizing quality, cost-effective health care for lesbian, gay, bisexual and transgender people.
https://www.lgbthealtheducation.org/

GLMA: Health Professionals Advancing LGBT Equality was founded in 1981 to ensure equality in health care for lesbian, gay, bisexual and transgender individuals and health care providers, including physicians, nurses, physician assistants, researchers, behavioral health specialists and health profession students. GLMA provides resources for both patients and providers and offers continuing education opportunities.
http://www.glma.org/

The Williams Institute at UCLA Law School supports research into LGBT health and health disparities, among many other areas of public policy that impact LGBT individuals and communities, including criminal justice and education policy.
https://williamsinstitute.law.ucla.edu/

National Women's Law Center is an ally in fighting gender-based discrimination. They have developed a helpful legal-focused toolkit on using Section 1557 of the ACA to enable advocates and policy makers to learn more about the scope and application of this provision.
https://nwlc.org/resources/

State-Based Resources on LGBT Health

Nashville CARES offers people living with HIV/AIDS and their families a unique combination of services, resources and referrals to help with the challenges of the disease. All services are based upon need, regardless of ability to pay. In addition to assisting with applications for Ryan White HIV/AIDS Program Funding, Nashville CARES provides education and testing for HIV, as well as referral and case management and social services and support for those with HIV infection and its complications.
http://www.nashvillecares.org

Program for LGBTI Health at Vanderbilt University Medical Center (VUMC) is an innovative effort to improve patient care, education, research and advocacy for the LGBTI community. The program offers inter-professional courses in LGBTI Health, provides educational resources for providers and patients and sponsors the Trans-Buddy program for transgender patients.
https://medschool.vanderbilt.edu/lgbti/

Tennessee Primary Care Association's LGBT Toolkit was developed for navigators and enrollers working in collaboration with Navigator Agencies and in community health centers across Tennessee. It was a joint project between the Tennessee Primary Care Association (TPCA) and the Tennessee Health Care Campaign through a grant from Community Catalyst. TPCA also provides ongoing training and support to community based health centers across our state.
http://www.tnpca.org/OE_LGBT_Toolkit*http://www.tnpca.org/OE_LGBT_Toolkit*

State-Based Resources for LGBT Advocacy

PFLAG, which historically stood for Parents, Families and Friends of Lesbians and Gays, (www.pflag.org) is a national organization that "has been saving lives, strengthening families, changing hearts, minds and laws" to promote the health and well-being of gay, lesbian, bisexual, transgender and queer people; their families and friends through support and advocacy work through local chapters since 1972. Tennessee is blessed to have local chapters throughout the state, including in Nashville (www.pflagnashville.org), which has been a partner in this publication, as well as in Chattanooga, Cookeville, Crossville, Franklin, Maryville, Memphis, Oak Ridge, Tri-Cities and Winchester (see https://www.pflag.org/find-a-chapter for contact information).

Tennessee Equality Project (TEP) engages state and local governments on behalf of the gay, lesbian, bisexual and transgender community. TEP has been instrumental in opposing discriminatory state legislation and helps advance nondiscrimination and partner benefits measures at the local government level.
http://tnep.nationbuilder.com/

Tennessee AIDS Advocacy Network (TAAN) is a non-partisan association of people affected by and concerned about HIV/AIDS in Tennessee. TAAN's mission is to improve awareness among policymakers and the public and to improve and strengthen the safety net of HIV prevention, care, treatment and support in Tennessee. TAAN works closely with Tennessee Department of Health's HIV/AIDS/STD Program and is supported by Nashville CARES.
http://www.tnaids.org

Tennessee Transgender Political Coalition (TTPC) educates and advocates on behalf of transgender related legislation at the federal, state, and local levels. It is dedicated to raising public awareness and building alliances with other organizations concerned with equal rights legislation.
https://www.facebook.com/tntpc

Tennessee VALS (TVALS) is a nonpolitical educational, social and support organization founded and designed to educate and support persons dealing with personal issues and concerns related to sexual/gender identity for transgender persons and those in relationships with transgender persons. TVALS also works to promote a positive public image for transgender persons.
http://www.tvals.org/

Gay Lesbian Straight Education Network, or GLSEN®—said as "glisten"—is a national organization that has been championing LGBTQ issues in K–12 education since 1990. Its Tennessee chapter offers teacher trainings, student support and community outreach.
https://www.glsen.org/chapters/middletn

American Civil Liberties Union—TN Chapter (ACLU) stands against discrimination in many different areas of state policy. The ACLU is a leading partner in efforts to protect civil rights of LGBT youth in the state legislature and local school district cases.
http://www.aclu-tn.org

Bi Tennessee is a community organization providing support and building community to empower bisexual, pansexual, fluid, queer, QPOC and unlabeled individuals living in Tennessee. The group also conducts educational trainings to increase understanding about the unique social and health needs of bisexual people.
https://www.meetup.com/Bi-Tennessee/

National Resources for LGBT Advocacy

National Transgender Law Center (TLC) works to change law, policy and attitudes so that all people can live safely, authentically, and free from discrimination regardless of their gender identity or expression. In addition to supporting the Trans Legal Services Network of attorneys across the country to help people navigate the complicated name and gender change process and other legal needs, TLC offers resources and research on efforts to promote transgender health benefits at national, state and workplace levels.
https://transgenderlawcenter.org

National Center for Transgender Equality is a national social justice advocacy organization devoted to ending discrimination and violence against transgender people through education and advocacy. It was founded in 2013 by transgender activists. Projects include the Racial and Economic Justice Initiative and the release of the 2015 U.S. Transgender Survey described in this report.
http://www.transequality.org/

National Center for Lesbian Rights, founded in 1977, is a nonprofit public-interest law firm committed to advancing the civil and human rights of lesbian, gay, bisexual and transgender people and their families through litigation, legislation, policy and public education. Their legal work spans case law related to not only healthcare but also to asylum and immigration, housing, family law, senior law and criminal justice.
http://nclrights.org

Movement Advancement Project is an independent think tank that provides rigorous research, insight and analysis to public audiences, including policymakers, funders, media and advocates, in order to help speed full equality for LGBT people. Their recent publication *The Invisible Majority: The Disparities Facing Bisexual People and How to Remedy Them* is described in this report.
http://www.lgbtmap.org

Lambda Legal was founded in 1973 as a nonprofit law firm that has initiated precedent-setting legal action against discrimination against LGBT people in housing, education, criminal justice, healthcare and marriage equality. Their 2010 report of a national survey on discrimination in health care settings—*When Health Care Isn't Caring*—established principles of health care fairness that were incorporated into ACA policy. Their website describes protections for LGBT people in current Tennessee state law in healthcare, workplace, parenting, schools and so forth and enables comparison with legislation in other states.
http://www.lambdalegal.org/

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Appendices

Note: The following two appendices are adapted from *Best Practices for Asking Questions About Sexual Orientation on Surveys,* published by The Williams Institute at the University of California Los Angeles.[1]

Appendix 1.1: Best Practices for Collecting Sexual Orientation Information

Self-Identification: How one identifies one sexual orientation:

Do you consider yourself to be …

a) heterosexual or straight,
b) gay or lesbian
c) or bisexual?

Sexual behavior: the sex of sex partners:

In the past (time period; e.g., year) who have you had sex with?

a) Men only.
b) Women only.
c) Both men and women.
d) I have not had sex.

Sexual attraction: the sex or gender of individuals that someone feels attracted to:

People are different in their sexual attraction to other people. Which best describes your feelings?

a) Attracted to only females.
b) Attracted mostly to females.
c) Attracted equally to females and males.
d) Attracted mostly to males.
e) Attracted to only males.
f) Not sure.

1. Sexual Minority Assessment Research Team (SMART), *Best Practices for Asking Questions About Sexual Orientation on Surveys,* The Williams Institute at the University of California Los Angeles School of Law, published November 2009, accessed 9 June 2017, *http://williamsinstitute.law.ucla.edu/wp-content/uploads/SMART-FINAL-Nov-2009.pdf.*

Appendix 1.2: Best Practices for Collecting Gender Identity and Transgender Status Information

Recommended measures for the "two-step" approach:

What sex were you assigned at birth, on your original birth certificate?

a) Male
b) Female

How do you describe yourself? (check one)

a) Male
b) Female
c) Transgender
d) Do not identify as female, male, or transgender

Recommended measure for single-item transgender/cisgender status approach:

Some people describe themselves as transgender when they experience a different gender identity from their sex at birth—for example, a person born into a male body but who feels female or lives as a woman. Do you consider yourself to be transgender?

a) Yes, transgender—male to female.
b) Yes, transgender—female to male.
c) Yes, transgender—gender nonconforming.
d) No.

Appendix 2.1: Comparison of Gender Reassignment Surgery Protocols in 2017 Tennessee Marketplace Plans*			
	BlueCross BlueShield of Tennessee (BCBST)	**Cigna**	**Humana**
Definition of scope from plan documents	*Gender reassignment surgery* is a term used to describe various medical/surgical treatments related to alleviating gender dysphoria in individuals who are transsexual, transgender or gender nonconforming. Treatment options include ... • changes in gender expression and role, which may involve living part time or full time in another gender role, consistent with one's gender identity. • hormone therapy to feminize or masculinize the body. • surgery to change primary/secondary sex characteristics. • psychotherapy for purposes such as exploring gender identity, role and expressions; addressing negative impact of gender dysphoria and stigma on mental health; alleviating internalized transphobia; enhancing social and peer support; improving body image or promoting resilience.	Gender reassignment surgery is intended to be a permanent change, establishing a congruency between an individual's gender identity and physical appearance and is not easily reversible. Therefore, a careful and accurate diagnosis is essential for treatment and can be made only as part of a long-term diagnostic process involving a multidisciplinary specialty approach (primary care provider, gynecologist, endocrinologist, urologist, clinical psychiatrist/psychologist, surgeon and plastic surgeon). Prior to gender reassignment surgery, patients usually undergo hormone replacement therapy, and this continues after surgery. Psychiatric care may need to continue for several years after surgery as major psychological adjustments may continue to be necessary.	*Gender dysphoria* refers to discomfort or distress caused by a discrepancy between an individual's gender identity and the gender assigned at birth (and the associated gender role and/or primary and secondary sex characteristics). A diagnosis of gender dysphoria requires a marked difference between the individual's expressed/experienced gender and the gender others would assign him or her, and it must continue for at least six months. This condition may cause clinically significant distress or impairment in social, occupational or other important areas of functioning. Gender reassignment surgery is performed to change primary/secondary sex characteristics.
Criteria to qualify for female-to-male reassignment: mastectomy, gonadectomy, genital reconstructive surgery	18 years or older. Capacity to make fully informed consent to treatment. Documentation shows persistent and well-documented gender dysphoria. Documentation that individual has lived continuously for 12 months in a real-life experience in the gender role congruent with gender identity. Documentation of 12 months of continuous hormonal therapy. *For mastectomy:* Only one referral letter required, and record of hormone therapy not noted. *For gonadectomy or genital reconstruction surgery:* Two referral letters from mental health professionals with a minimum of a master's or doctoral degree in clinical psychology. The first letter should come from the individual's psychotherapist; the second, from professional who has only an evaluative role.	18 years or older. Confirmed gender dysphoria. Documentation that individual has lived continuously for 12 months in a real-life experience in the gender role congruent with gender identity. Documentation of 12 months of continuous hormonal therapy. *For mastectomy:* Only one referral letter required, and record of hormone therapy not noted. *For gonadectomy or genital reconstruction surgery:* Two referral letters from mental health professionals with a minimum of a master's degree or equivalent in a clinical behavioral science field and continuing education in the assessment and treatment of gender dysphoria. One letter must come from the individual's psychotherapist; the second, from professional who has only an evaluative role. Letters to be submitted to the physician performing the genital surgery.	18 years or older. Capacity to make fully informed consent to treatment. Documentation shows persistent and well-documented gender dysphoria. Documentation of 12 months of continuous hormonal therapy. *For mastectomy:* only 1 referral letter required and record of hormone therapy not noted. *For gonadectomy or genital reconstruction surgery:* Two referral letters from mental health professionals with a minimum of a master's or doctoral degree in clinical psychology. The first letter must come from the individual's psychotherapist; the second, from a professional who has only an evaluative role. *For genital reconstruction surgery:* Documentation that individual has lived continuously for 12 months in a real-life experience in the gender role congruent with gender identity.

	BCBST	Cigna	Humana
Criteria to qualify for male-to-female reassignment: gonadectomy, genital reconstruction surgery	18 years or older. Capacity to make fully informed consent to treatment. Documentation shows persistent and well-documented gender dysphoria. Documentation that individual has lived continuously for 12 months in a real-life experience in the gender role congruent with gender identity. Documentation of 12 months of continuous hormonal therapy. Two referral letters from mental health professionals—the first, from the individual's psychotherapist; the second, from a professional who has only an evaluative role.	18 years or older. Documentation shows persistent and well-documented gender dysphoria. Documentation that individual has lived continuously for 12 months in a real-life experience in the gender role congruent with gender identity. Documentation of 12 months of continuous hormonal therapy. Two referral letters from mental health professionals—the first, from the individual's psychotherapist; the second, from a professional who has only an evaluative role. Letters to be submitted to the physician performing the genital surgery.	18 years or older. Documentation shows persistent and well-documented gender dysphoria. Documentation that individual has lived continuously for 12 months in a real-life experience in the gender role congruent with gender identity. Documentation of 12 months of continuous hormonal therapy. Two referral letters from mental health professionals—the first, from the individual's psychotherapist; the second, from a professional who has only an evaluative role. Letters to be submitted to the physician performing the genital surgery. *For genital reconstruction surgery:* Documentation that individual has lived continuously for 12 months in a real-life experience in the gender role congruent with gender identity.
Credentials of therapists	Minimum of a master's degree or PhD in clinical psychology.	Master's degree or equivalent in a clinical behavioral science field or a more advanced degree. Credentials from a state licensing board. Competence in using the DSM-5 or ICD for diagnostic purposes. Ability to recognize and diagnose coexisting mental health concerns and to distinguish these from gender dysphoria. Documented supervised training and competence in psychotherapy or counseling. Continuing education in the assessment and treatment of gender dysphoria.	Master's degree or equivalent in a clinical behavioral science field or a more advanced degree. Credentials from a state licensing board. Competence in using the DSM-5 or ICD for diagnostic purposes. Ability to recognize and diagnose coexisting mental health concerns and to distinguish these from gender dysphoria. Documented supervised training and competence in psychotherapy or counseling. Continuing education in the assessment and treatment of gender dysphoria.
Contents of support letter	Individual's general identifying characteristics; results of psychosocial assessment, including any diagnoses. Duration of mental health professional's relationship with the client, including the type of evaluation and therapy or counseling to date. Explanation that the criteria for surgery have been met. A brief explanation of the clinical rationale for supporting the individual's request for surgery. A statement about the fact that informed consent has been obtained. A statement that the mental health professional is available for coordination of care and welcomes a phone call to establish this.	Individual's general identifying characteristics. Initial and evolving gender, sexual and psychiatric diagnoses. Details regarding type and duration of psychotherapy or evaluation individual received. Documentation of the extent to which eligibility criteria have been met. Mental health professional's rationale for hormone therapy or surgery. Degree to which the individual has followed the standards of care and likelihood of continued compliance. Whether or not the mental health professional is a part of a gender team.	Individual's general identifying characteristics results of psychosocial assessment, including any diagnoses. Duration of mental health professional's relationship with the client, including the type of evaluation and therapy or counseling to date. Explanation that the WPATH criteria for surgery have been met, a brief explanation of the clinical rationale for supporting the individual's request for surgery. A statement about the fact that informed consent has been obtained. A statement that the mental health professional is available for coordination of care and welcomes a phone call to establish this.
Exclusions	Abdominoplasty, facial plastic or cosmetic surgery, breast enhancement, implants, laryngoplasty, nipple reconstructions, skin resurfacing and voice modification surgery or lessons	Abdominoplasty, facial plastic or cosmetic surgery, breast enhancement, implants, laryngoplasty, nipple reconstructions, skin resurfacing and voice modification surgery or lessons	Abdominoplasty, facial plastic or cosmetic surgery, breast enhancement, implants, laryngoplasty, nipple reconstructions, skin resurfacing and voice modification surgery or lessons
Reproductive preservation	Not addressed in the Gender Reassignment policy	Does not cover cryopreservation, storage and thawing of reproductive tissue because each is considered experimental, investigational or unproven.	Does not cover cryopreservation, storage and thawing of reproductive tissue because each is considered experimental, investigational or unproven.
Disclaimer in plan document	A specific health plan policy that might differ from this policy does override this policy statement.	A specific health plan policy that might differ from this policy does override this policy statement.	A specific health plan policy that might differ from this policy does override this policy statement. Pharmacy Benefit and Behavioral Benefit sections should also be consulted. Any state mandates for gender reassignment surgery take precedence over this clinical policy.
Source document	**BlueCross BlueShield of Tennessee Medical Policy Manual** *http://www.bcbst.com/MPManual/Gender_Reassignment.htm*. Accessed 2/9/2017.	**Cigna Medical Coverage Policy Number 0266 on Gender Reassignment Surgery** Effective Date 3/15/2016	**Humana Medical Coverage Policy on Gender Reassignment Surgery** Effective Date: 01/01/2017
Note: All plans referenced medical criteria based on the World Professional Association for Transgender Health (WPATH) 2012 Guidelines and the term *gender dysphoria* as defined in DSM-5.			

Appendix 2.2: What to Do If You Feel You Have Been Discriminated Against by an Insurer or Provider

Step 1

If you feel you have been treated unfairly by an insurer or a provider, you should first bring this to the attention of your insurer. You can do it over the phone using the phone number on your insurance card, but it is best to also "put it in writing" and keep a copy of whatever you send to your insurer.

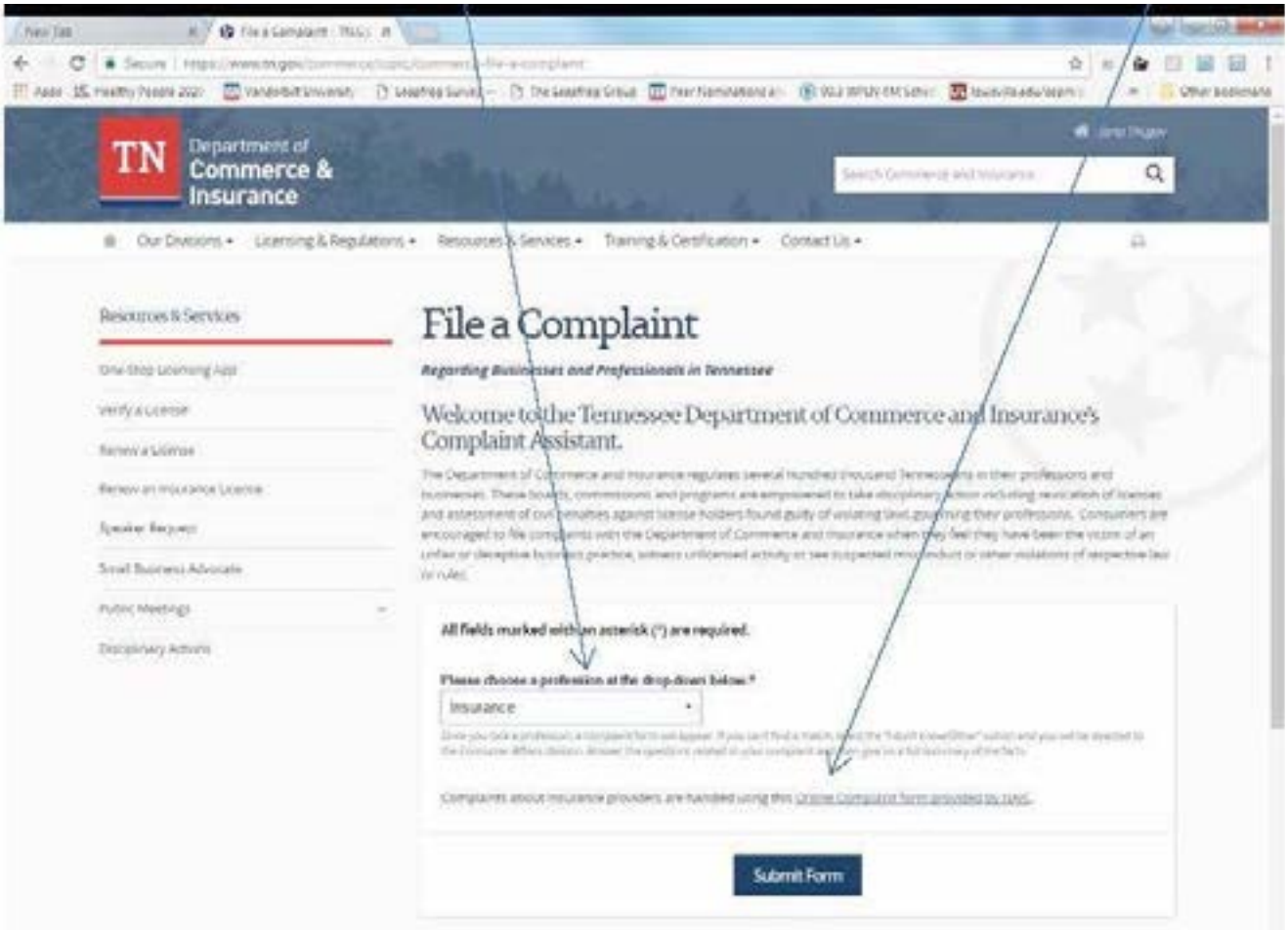
You will need to be as specific as possible about what happened, when, where, who you spoke to, and to be sure to keep copies of any documents that are related to the complaint. If you have not submitted a complaint before, we advise that you seek support in preparing the complaint:

- If the complaint is in regard to HIV-related care, we recommend you contact Nashville CARES Insurance Assistance Program at 615-259-4866, which provides assistance statewide.
- If the complaint is in regard to care provided by an MCO under TennCare, we recommend you contact the Tennessee Justice Center at 615-255-0331 to discuss your complaint.
- If the complaint is in regard to health discrimination under an ACA marketplace plan, you can contact the THCC Connector at 844-644-5443 to schedule an appointment with a navigator for advice in preparing the complaint.

Step 2

If you have been unable to resolve the concern with your insurer, a complaint should be filed with the Tennessee Department of Commerce and Insurance (TDCI) on their website: https://www.tn.gov/commerce/topic/commerce-file-a-complaint.

From the "choose a profession" drop-down menu, choose "Insurance" and go to the "Online Complaint" form.



Although you can submit directly online, we recommend that you print out the form or make a copy of the complaint form. Again be as specific as possible, and make a copy of what you submit. Also keep copies of any documents related to your complaint and fax or mail them along with your complaint to TDCI.

When a complaint is received, the Consumer Insurance Services Division of TDCI will assign it to a staff member, who will meet with the insurer to try to resolve the issue. The consumer will be advised in writing of whether or not any resolution could be reached. (***Note:*** A Tennessee consumer is currently not invited to be a party to these meetings!) There is no provision for further appeal through TDCI.

Step 3

If the complaint is related to being LGBT, you can also consider filing your complaint with the Office of Civil Rights (OCR) in the Department of Health and Human Services (HHS). If you need to go to this level, then you should consider contacting an ally organization such as the National Center for Transgender Equality.

To file such a complaint, go to https://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html. Note, however, that as of April of 2017, the HHS OCR has posted this new notice [bolding added] on their website, which puts in question their willingness to enforce Section 1557:

> Section 1557 has been in effect since its enactment in 2010 and the HHS Office for Civil Rights has been enforcing the provision since it was enacted.
>
> **On December 31, 2016, the U.S. District Court for the Northern District of Texas issued an opinion in Franciscan Alliance, Inc. et al v. Burwell, enjoining the Section 1557 regulation's prohibitions against discrimination on the basis of gender identity and termination of pregnancy on a nationwide basis. Accordingly, HHS' Office for Civil Rights (HHS OCR) may not enforce these two provisions of the regulation implementing these same provisions, while the injunction remains in place.** Consistent with the court's order, HHS OCR will continue to enforce important protections against discrimination on the basis of race, color, national origin, age or disability, as well as other sex discrimination provisions that are not impacted by the court's order.
>
> If you believe you have been discriminated against on one of the bases protected by Section 1557, you may file a complaint with OCR.

Appendix 3.1: Detailed Description of Rating Areas and Plans								
Rating area	1 — East	2 — Greater Knoxville	3 — Greater Chattanooga	4 — Greater Nashville	5 — West	6 — Greater Memphis	7 — East Central	8 — West Central
Insurers and plan choices (B = Bronze; S = Silver; G = Gold)	Cigna: 3B, 4S and 1G BCBST: 1B, 2S and 1G	Humana: 1B and 1S	BCBST: 1B, 2S and 1G	Cigna: 3B, 4S and 1G Humana: 1B, 1S and 1G	BCBST: 1B, 2S and 1G	Cigna: 3B, 3S and 1G Humana: 1B and 1S	BCBST: 1B, 2S and 1G	BCBST: 1B, 2S and 1G
Cost of second-lowest Silver plan premium	$329.65	$354.86	$510.59	$356.52	$528.27	$354.12	$464.02	$529.79
Number enrolled (2016 CMS enrollment report)	19,932	49,401	26,542	76,002	17,789	44,772	14,674	19,798
Number adults estimated in coverage gap	31,720	70,210	40,546	95,736	29,452	70,745	24,926	28,920
Counties	Carter	Anderson	Bledsoe	Cheatham	Benton	Fayette	Cannon	Bedford
	Greene	Blount	Bradley	Davidson	Carroll	Haywood	Clay	Coffee
	Hancock	Campbell	Franklin	Montgomery	Chester	Lauderdale	Cumberland	Dickson
	Hawkins	Claiborne	Grundy	Robertson	Crockett	Shelby	DeKalb	Giles
	Johnson	Cocke	Hamilton	Rutherford	Decatur	Tipton	Fentress	Hickman
	Sullivan	Grainger	Marion	Sumner	Dyer		Jackson	Houston
	Unicoi	Hamblen	McMinn	Trousdale	Gibson		Macon	Humphreys
	Washington	Jefferson	Meigs	Williamson	Hardeman		Overton	Lawrence
		Knox	Polk	Wilson	Hardin		Pickett	Lewis
		Loudon	Rhea		Henderson		Putnam	Lincoln
		Monroe	Sequatchie		Henry		Smith	Marshall
		Morgan			Lake		Van Buren	Maury
		Roane			Madison		Warren	Moore
		Scott			McNairy		White	Perry
		Sevier			Obion			Stewart
		Union			Weakly			Wayne

Appendix 3.2: Statewide Variations in the Cost of Selected Health Care Plans Among Rating Areas—Impact of Age						
Rating area	Silver plan selected for comparison in this report	Comparison A Subsidized annual premium calculated for a 60-year-old earning $20,000/year by Healthcare.gov	Comparison B Premium tax subsidy for a 60-year-old earning $20,000/year	Comparison C Out-of-pocket maximum (OOPM) for a 60-year-old earning $20,000/year	Comparison D Maximum total yearly cost of health care (premium + OOPM) for a 60-year-old earning $20,000/year	Full annual premium price of selected plan for a 60-year-old not eligible for subsidy (earns >400% of FPL)
1	Cigna 3500/700***	$2,744	$8,892	$2,000	$4,744	$11,633
	BCBST S04S***	$2,767	$8,892	$1,600	$4,367	$11,656
2	Humana 3550/900**	$988	$9,648	$2,050	$3,038	$10,632
3	BCBST S04S*	$0	$14,304	$1,600	$1,600	$12,900
4	Cigna 3500/700***	$2,887	$9,696	$2,000	$4,887	$12,580
	Humana 3550/900***	$3,049	$9,696	$2,050	$5,099	$12,742
5	BCBST S04S*	$0	$14,844	$1,600	$1,600	$13,347
6	Cigna 3500/700***	$2,834	$9,624	$2,000	$4,834	$12,456
	Humana 3550/700***	$1,226	$3,264	$2,050	$3,276	$10,848
7	BCBST S04S*	$0	$12,912	$1,600	$1,600	$11,724
8	BCBST S04S*	$0	$14,880	$1,600	$1,600	$13,385

* Lowest-priced Silver plan in the rating area ** Benchmark (second-lowest-priced premium) Silver plan in the rating area
*** Premium priced above the benchmark Silver pan

Appendix 3.3: How Failure to Expand Medicaid Impacts LGBT Health in Tennessee

When the ACA was originally passed, the marketplace plans and subsidies were designed to help individuals and families earning over 100 percent of the Federal Poverty Level (FPL) afford private coverage. The ACA intended that all individuals and families earning less than 100 percent of the FPL would be covered by Medicaid, which is known as TennCare in Tennessee.

For over 50 years, Medicaid has been a federal–state funding partnership to cover health care for poor children under age 19, pregnant women, elderly persons who are poor and people with disabilities. In recent years, parents of children living under the FPL have also been included in coverage. The Medicaid program is administered by states, but the federal government has contributed to the cost of care according to a formula based on the percent of a state's population living in poverty. At this time in Tennessee, the federal match is 65 percent of the total cost; the state budget covers the other 35 percent.

The ACA would have extended Medicaid coverage to adults without children or with adult children but earning under 138 percent of the FPL. The 100-to-138-percent overlap was in recognition that incomes fluctuate from year to year for persons working low-wage jobs, based on availability of hours worked. This overlap avoids needing to abruptly disenroll people if their incomes move slightly over 100 percent of FPL. In Tennessee, an estimated 280,000 to 350,000 adults have incomes within this range. To buffer the impact of this sudden expansion on state budgets, the ACA set the federal match at 100 percent of the additional cost for the first three years of expansion and then gradually moved to a guaranteed 90-percent match over a five-year period.

However, this part of the ACA was challenged in court, and in a 2012 decision, the Supreme Court ruled that Medicaid expansion could not be required of states but could be presented as an option. About half of the states immediately moved to expand Medicaid. Other states requested special waivers to design special programs for the expansion population.

In Tennessee, Governor Haslam proposed such a waiver-based expansion called Insure Tennessee, which differed from the regular TennCare program in several ways, including giving working persons the option of receiving a state subsidy to buy into an employer-based plan if one was offered where they worked or to choose a TennCare plan but to pay modest copays for some of their health care needs. However, the governor was not successful in getting this legislative priority passed by the state legislature, the Tennessee General Assembly, in 2015. Both Governor Haslam and the Tennessee legislative leadership have refused to revisit the issue, despite the loss of over $3.14 billion in revenue to the state and the closures of nine rural hospitals, which could not weather the cost of caring for uninsured Tennesseans with serious health care needs. High uncompensated hospital care costs also drive up the cost of care and the cost of premiums for everyone in the state.

Previously uninsured Tennesseans in that 100-to-138-percent-of-FPL income range have the option of purchasing a plan on the ACA marketplace. Many have done so, especially those who have serious illnesses, though it means paying premiums not required on a TennCare plan. Those who have purchased marketplace plans have had medical expenses much higher than predicted by insurers, resulting in higher premiums for all on the exchanges.

With a new federal administration intent on reversing the federal funding for Medicaid expansion, it is unclear how low-income adults in this coverage gap will be able to access health care coverage in Tennessee in the near future. Many LGBT individuals are in this gap, especially those working in the arts, entertainment and food service industries; students; and teens without support from their families because of their sexual orientation and gender identity. In summary, failure to expand Medicaid will result in poorer health for many LGBT individuals, and potential fallout from policy changes to Medicaid needs to be tracked to insure protection of LGBT Tennesseans and their dependents who rely on Medicaid for care.